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ABSTRACT

This report describes (1) the development of a comprehensive and interdisciplinary approach to early health assessment and follow-through for 750 children in day care centers and family day care homes, and (2) training and consultation provisions for day care staffs to aid children and their families. Objectives of the three year project were to provide medical screening, developmental assessment, mental health screening, and staff training and consultation: to implement follow-up procedures: to promote record-keeping: to facilitate parent contact and involvement: and to demonstrate the use of a multi-disciplinary team serving day care centers. After a project overview, Part II of the report describes the interdisciplinary and comprehensive approach employed, discusses health assessment and follow-through procedures, consultation and training activities, the extention of the program into family day care homes, and service coordination efforts and their impact. Part III of the report details the evaluation component of the report, while Part IV provides a summary of findings. Generally, findings indicated that the use of interdisciplinary project teams provides a means of enhancing preventive health care for young children. It is also argued that day care centers could provide primary health support for families and augment the secondary support role of agencies by promoting coordination of local resources for families using day care. (Author/RH)

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Final Report
# of the
Demonstration and Evaluation
for the
City/University
EPSDT Day Care Project

Edited by
Ebba L. Hierta

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Special thanks go to the staffs of the day care centers which participated in our project. Their ideas, encouragement, and forbearance contributed much to the development of the project and its products.

Staff of the City/University EPSDT Day Care Project

*Pearl G. Axelrod, Project Director 1976-1978
*Wilbur J. Cohen, Project Director 1978-1979
*Mimi Harris, Associate Project Director 1976-1977
*Ebba Hierta, Associate Project Director 1977-1979

*Carol Alexander
*Tobi Hanna Bartlett
Niyonu Benson
Christy Chandler
*Lynn Clarke
*Virginia duRivage
Jackie Foster
William Hart
*Helen Hasenfeld
*Ellen Kotlus
Babette Kronstadt
Valerie Lovelace

Roxanne Lozen
Juanita Mendez
Sally Perkins
*Thelma Perry
*Dorothy Simpson
Sharon Singleton
Diane Sobell
Brenda Taylor
Carol Urkhart
*Marcia Van Possen
*Esmeralda Watkins
Frieda Williams
Sue Woodruff

Evaluation Staff

*Nancy Shiffler
*Margaret McNiven
Jeanne Martin

Ruth Elberger
Elizabeth Gilliam
Pecolia Jarmond

*This is a roster of the staff over a three year period. Normally, there were fifteen staff members employed at any one time, about half of them part time. Those persons starred were members of the project as it came to a close and assisted in preparing this final report.

Many helpful and innovative training materials were developed which are useful for those involved in child care and service coordination: day care centers, day care homes, families, and the varied community services working on behalf of young children and their families. These materials are available through The University of Michigan, School of Education.

This project was supported in part by grant #11-P-90442/5-03, awarded by the Health Care Financing Administration (HCFA), DHEW, to The University of Michigan and the City of Ann Arbor through the Michigan Department of Social Services. The contents of the surveys and questionnaires are not the responsibility of HCFA.

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PREFACE

The City/University EPSDT-Day Care Project was a three-year research and demonstration project funded by DHEW to the Michigan Department of Social Services, and the project was jointly carried out by The University of Michigan School of Education and the City of Ann Arbor. The Project served a population of approximately 750 children and their families through day care centers and family day care homes in Washtenaw County. It developed a comprehensive and interdisciplinary approach to early health assessment and follow-through for children and for training and consultation for day care staffs on behalf of children and their families. The project's innovative approach explored adaptations of the Early and Periodic Screening, Diagnosis and Treatment model. This approach included making available a separate developmental assessment on-site for each child in the day care setting.

In addition to developmental assessments for children, interdisciplinary project teams, which included a nurse, social worker, and an education practitioner, provided systematic consultation and training to the children's caregivers, based on goals set with the day care staffs. This interdisciplinary team approach affected outreach, assessment of the "whole child's" health, follow-up, case monitoring, and technical assistance in two ways. It demonstrated a means of enhancing preventive health care for young children. In doing so, it emphasized the primary support day care centers could provide for families. In turn, this augmented the secondary support role of agencies by promoting coordination of local resources for families using day care. The long-range implication of these methods is to increase mutual helping between day care staff and families for the well-being of the children involved.

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CHAPTER 1: OVERVIEW

The City/University EPSDT Day Care Project has accomplished its major goal. It has demonstrated that a meaningful comprehensive child health assessment program can be implemented through day care. In so doing, it has demonstrated the use and benefits of coordinated, interdisciplinary teams to provide outreach, assessment of the "whole child's" health, follow-up, case monitoring, and technical assistance to caregivers. With this assistance, caregivers have been better able to address the special needs of children during the crucial developmental period from birth to five years, and have better met the needs of these children's families. In addition, the Day Care Project has field-tested a program of day care support for continuity of comprehensive health care, a model which may be useful in future policy planning on a local, state, or federal basis.

Before continuing with this report, some terms should be clarified. In this report, comprehensive is used in two senses. First, it is used in a linear sense to mean outreach, assessment, and follow-up, which includes case monitoring and long-term follow-through. Second, it is used in a more global sense to refer to a "whole-child" philosophy of health: health is seen as an interdependent relationship between physical, cognitive, social, emotional, and environmental aspects of the child's development.

Since the system developed by the project for comprehensive child health assessment through day care is consistent with the kind of assessment recommended in Developmental Review as expressed in the 1977 Final Report prepared by the American Association of Psychiatric Services for Children, we will also use two of their terms: assessment, to describe the process of our comprehensive health methods, and screening, to describe the medical assessment stage of our review of children's health.

National Health Care Resources

In the past decade there have been concentrated federal, state, and local efforts to develop new programs and to strengthen existing resources that provide early detection of health problems, better routine health care, and necessary health care support services for young children. Early Periodic Screening, Diagnosis and Treatment (EPSDT), is one such effort. A national medicaid program enacted in 1967, EPSDT is designed to screen and provide treatment for the health and developmental needs of young children from medicaid-eligible low-income families. Additional funds, available under federal law P.L. 94-142 and Michigan's Public Act 198, may be used to locate and educate handicapped children age three and older. Funds from the Michigan-developed Child Find Project, a response to federal mandates, may be used to better identify and educate handicapped children from birth onward.

In addition to these resources, a variety of provider channels are available through the federal programs of the Office of Human Development, the Office of Education, the Office of the Assistant Secretary for Health, and the Social Security Administration. These resources are elaborated by Bruce S. Wolff, special assistant to the secretary of the Department of Health, Education and Welfare, in the 1978 report entitled, "HEW Program Opportunities to Expand and Enhance the Delivery of EPSDT/CHAP Services."

In spite of this seeming wealth of resources, children's health needs are not being met. We are not reaching enough of the children we are seeking to help, nor are we following through with those children we do reach. In 1977, the Children's Defense Fund reported two years of study on EPSDT in, EPSDT: Does It Spell Health Care for Poor Children? The fund reported that EPSDT, the largest federal health program for the early detection and routine care of children's health problems, reached less than one-fourth of the 13 million children eligible for its services. Furthermore, EPSDT often inadequately served those it did reach: only 60 percent of the approximately 1.1 million health problems identified as requiring follow-up care were treated. During the two years of the study, a half-million diagnosed health problems went untreated. The conditions identified but untreated were largely vision and hearing disorders, serious dental problems, and anemia--problems which create barriers to a child's daily ability to learn, to eat properly, and to live a productive, rewarding life. The Children's Defense Fund also reported that one out of every seven children in the U.S.--about 10 million children--had no known source of primary health care. And one out of every three children under seventeen, more than 18 million children, had never seen a dentist.

The benefits of EPSDT are limited by its failure to reach needy children and its inadequate follow-up on some children it does reach. The benefits of EPSDT are further limited by restrictions which make many needy children ineligible for services. Medicaid allows EPSDT coverage for only two groups: those eligible for Aid to Families with Dependent Children (AFDC) and those eligible for Supplement to Security Income (SSI). Michigan also provides medical assistance to certain groups which do not qualify for AFDC or SSI (i.e., children of two-parent low-income families). But each state sets its own income and resource limits for AFDC, and nationwide a large proportion of the population of young children--those in poor but intact families--are not covered by EPSDT. (This need for wider eligibility and better follow-up has now been recognized by Congress, which has introduced DHEW Child Health Assessment Program (CHAP) legislation to alleviate the problems.)

According to the Wolff report, program policies and methodologies are one barrier to optimum EPSDT functioning. Another barrier is the lack of coordination between programs providing EPSDT services. This allows duplication of services in some areas, and fragmentation of services in others; gaps in service delivery and inhibited efficiency of service result.

The inventory of program-provider possibilities outlined in the Wolff report reveals a number of actions which could be taken by DHEW-funded programs and projects to improve coordination of outreach, follow-through, case management, and service delivery. However the report points out that without readily-identifiable health care providers, interagency agreement about the provision of care, and technical assistance to help implement and fine-tune the links between agencies, adequate comprehensive health assessment and care cannot be realized.

Child Health Care in Michigan

Michigan has begun an attempt to remediate some of the problems seen at the federal level by supporting a coordinated agency effort for the identification and treatment of children in need of health care. In 1977, the directors of the departments of Public Health, Education, Social Services, and Mental Health signed an interagency policy statement on preschool and parent education services that read, in part:

1) We support the concept of interagency planning for strengthening what is presently available, identifying what is missing, and implementing that which is possible;

2) We support collaborative use of existing programs and the recognition and compliance with applicable regulations;

3) We support the development of a coordinated early identification, referral, and treatment system for children and families with special needs.

In addition to this statement of intent, Michigan has a model program of health care. In 1975 the Michigan state Superintendent of Public Instruction and the director of the Michigan Department of Public Health identified the need for coordinated services to teenage mothers. A task force, convened on this topic, led to the establishment of the State Interagency Committee for Services to High Risk Children and their Families. This committee designed pilot programs which provide comprehensive services to pregnant adolescents, school-aged parents, and their families. In addition, they designed several screening systems to identify children from birth through five years who need evaluation or diagnosis for problem conditions in the physical, cognitive, language, social, and emotional realms.

This second role, the one our project has been most concerned with, was developed in response to the need for a consistent, statewide system for health assessment. While currently several programs screen for children with special needs, handicaps, or developmental disabilities, these programs are often both duplicative and fragmented, not assuring either that all children in need are reached, or that, when reached, adequate follow-up is provided.

Unfortunately, although the committee has developed recommendations for coordinated outreach, screening, and referral, by and large community programs are not yet following these recommendations. Community programs in Michigan at present suffer from inadequate provision for children from limited income families who are not eligible for medicaid; limited follow-through and case monitoring procedures; poor methods to identify health care providers; and lack of local interagency cooperation and program linkage.

The Michigan Special House Committee on Children Services, Representative David Hollister, Chairperson, corroborated these needs after a review of state services. The December 1978, Final Report stated:

> Programs for young children are not a priority in state government; Principles guiding the development and implementations of programs are not clearly developed or understood by department staff; Coordination and communication between departments administering similar programs is practically non-existent.

Health Care through Day Care Centers

EPSDT screening is traditionally done to bring children into the health care system. It does not, however, ensure that once in the system, children will receive the services they need. The goal of our project was to improve the delivery of needed services to children. And we chose to meet this goal through day care for several reasons. First, day care centers already offered a variety of services, but because of limited resources most were not able to provide all the services they wished; centers thus were open to our aid. Second, with increased numbers of young children in day care, the day care facilities offered an early opportunity to uncover, remediate, and prevent problems for increasingly large numbers of young children. Third, caregivers, who are with children for long periods of time at a malleable time in their development, could effect change more successfully than could agents in other family services later in the children's lives. Fourth, the day care centers provided an already-established contact not only with children, but also with the families of these children.

Further, day care centers were chosen because they are likely to be an increasingly important link between society and families in the future, and so an important provider resource channel to develop. Sandra Hofferth of the Urban Institute has published, "Day Care in the Next Decade, 1980 - 1990" (Journal of Marriage and the Family, August 1979, pp. 649-658). Based on an analysis of work trends and population, Hofferth predicts a 36 percent increase in the preschool child population during the 1980s with greater reliance on day care for infants and toddlers as well as for three- to five-year-olds. Hofferth's predictions suggest that for an ever-increasing proportion of our population, day care can provide the link between societal resources and the family. Governmental sources have already considered this possibility. In the executive summary of the 1974-1976 project for "The Implementation of EPSDT in Child Care Centers," Yvonne Ali states, "EPSDT programs can cooperatively work with the school health programs to implement EPSDT through schools and day care centers. In this way outreach costs will be reduced and...services in all EPSDT component areas can be implemented."

Finally day care was chosen because it is already the service channel through which the greatest number of low-income children are reached, and it could become an even larger channel if medicaid eligibility is reassessed. Sixty to seventy percent of children in day care who receive Title XX benefits are currently eligible for EPSDT. Many of these children could be helped at the center, as could an additional forty percent of Title XX recipients given revised medicaid eligibility. The day care center could come to function much as the Headstart program does, serving as a mechanism for the coordination of family-related services.

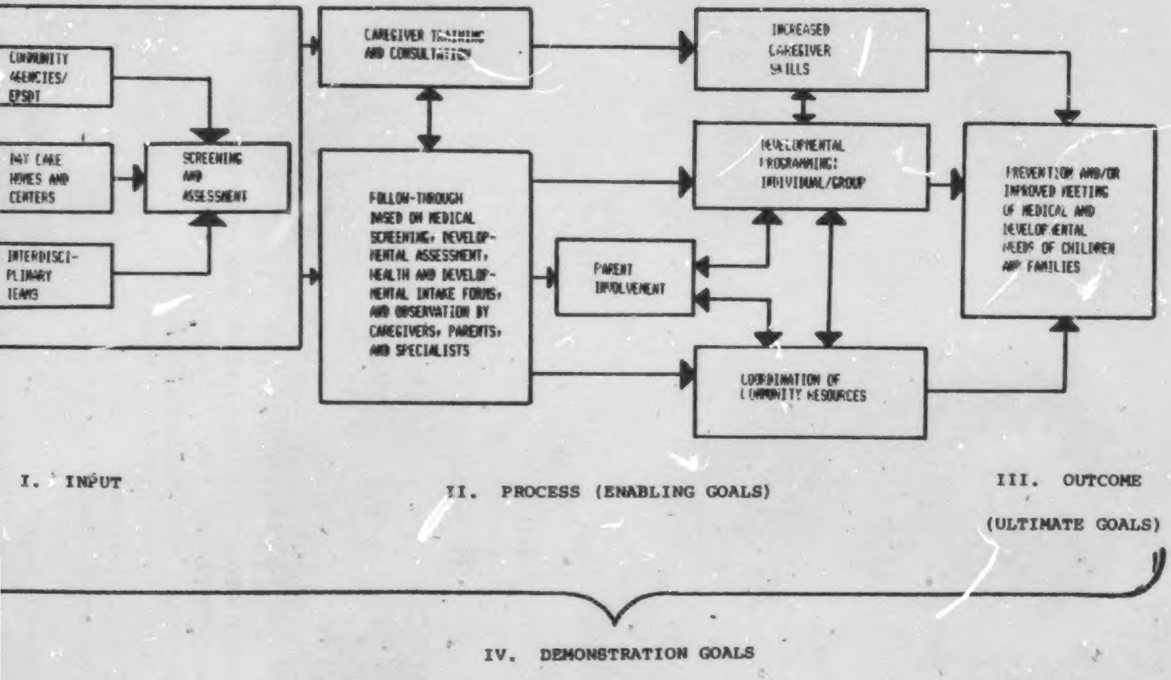
EPSDT-Day Care Project Goals

The day care center can, increasingly, provide a channel for consistent outreach, follow-up, case monitoring, and continous care. With the support of agency resources it can serve as a liason between the family and the community's resources, thereby returning agencies to their original function as a secondary support system. To aid this effort, the project developed an assessment process to help the community find children in day care with health and developmental problems and to ensure that these children receive the assistance they require. Using this process, day care centers can provide a developmentally-oriented program during which caregivers can identify children's problems, provide referrals where necessary, and note developmental progress and setbacks.

To do all this, services must be coordinated and caregivers must be trained. According to the recent Abt report, "Children at the Center," caregivers who have had child-related training deliver better care, which has a somewhat superior developmental effect on children. (Experience and formal education show no important relationship to these measures.) Such training, if implemented, is a big step in prevention. Centers and caregivers lack the time and the funds for this important training. Caregiver training became a major thrust of the City/University Day Care Project.

The project, then, focused on helping the community find children with health and developmental problems and on ensuring that these children received the assistance they required. The project also focused on providing technical assistance to help caregivers identify and work with special children in an optimal program. The result was a collaborative community agency which used interdisciplinary, public agency resources to assess and provide follow-up care for children in day care while it provided training and consultation for their caregivers. Figure 1 provides an overview of the framework for the project's demonstration goals.

FIGURE 1: CONCEPTUAL FRAMEWORK FOR INTERVENTION STRATEGY


COMMUNITY AGENCIES/ EPSDT
DAY CARE HOMES AND CENTERS
INTERDISCI-PLINARY TEAMS
SCREENING AND ASSESSMENT
CAREGIVER TRAINING AND CONSULTATION
FOLLOW-THROUGH BASED ON MEDICAL SCREENING, DEVELOP-MENTAL ASSESSMENT, HEALTH AND DEVELOP-MENTAL INTAKE FORMS, AND OBSERVATION BY CAREGIVERS, PARENTS, AND SPECIALISTS
PARENT INVOLVEMENT
INCREASED CAREGIVER SKILLS
DEVELOPMENTAL PROGRAMMING: INDIVIDUAL/GROUP
COORDINATION OF COMMUNITY RESOURCES
PREVENTION AND/OR IMPROVED MEETING OF MEDICAL AND DEVELOPMENTAL NEEDS OF CHILDREN AND FAMILIES
I. INPUT
II. PROCESS (ENABLING GOALS)
III. OUTCOME
(ULTIMATE GOALS)
IV. DEMONSTRATION GOALS

CHAPTER 2: OBJECTIVES OF THE PROJECT

During the three years of the project we adapted specific objectives within our larger project goals to meet day care center and family day care home needs and to accommodate community resources. The unifying threads throughout these changes, and the fundamental values held by the project, were our commitment to the "whole child" and to finding methods to provide more complete and contiauous service to the child and his or her family. The development of project goals based on our commitments and on community needs will be highlighted in this chapter. Appendix A1 lists our long- and short-term goals for the third year, as these best met both concerns.

Medical Screening

In the first year of the project we specified the number of children we hoped to have screened and the screening site: to be at the individual day care centers. Screening would be done by the health department staff; family day care homes would have screening done at the center nearest them.

In the second year our goals were similar, but the health department would do screening only at their regular facility; they found the on-site method inconvenient for their staff. We adapted to this condition by providing a project van to transport children, their parents, and project personnel to the county service center.

In the third year our objectives neither included goals for the number of children to be screened, nor cited the day care center as the site. For this year the health department did medical screenings only at the county service center, to which families provided their own transportation. Despite a major promotional effort by project staff in this year, the number of children screened fell below the numbers from the previous two years. There was also a greater response to the screening when it was offered on-site than when it was given at the health department's EPSDT facility. Perhaps more parents would have requested medical screening if we had been able to provide it at the day care site.

As we moved from the first to the third project year, our objectives became more specific regarding medical records. By the third year we recommended that each child's records contain a health and developmental history with a program for follow-up. Many centers adopted this policy and found it helpful. For all three years the project successfully met goals of securing health records on all children and followingup specific health conditions.

Developmental Assessment

It was our goal to provide a developmental assessment, on-site at the day care centers, to each child whose parent gave permission. That assessment was to be part of the EPSDT protocol for the children we screened. The objectives describing the manner in which it was to be done, along with the follow-up, changed during the life of the project. In the original proposal the Ann Arbor School District was to direct the assessment, from which individual programs would be developed. However the district had neither the interest nor the personnel to participate, so second and third year goals specified neither the Ann Arbor School District nor individual programming. Instead goals specified that parents would be provided with a narrative description of each child's performance and that each teacher would receive a composite developmental profile of his or her class in addition to copies of individual profiles (Appendices A11 and 12). During all three years of the project, any need for diagnosis of special problems was to be determined during consultation with center staff and parents. These goals were met.

The developmental assessment of children was done on-site, directed by project staff, all three years. Large numbers of children were assessed. However it quickly became apparent that the Developmental Indicators for the Assessment of Learning (DIAL), the developmental assessment instrument used by the project, was simply a screening device and, as such, did not provide enough specific information about a particular child to become the basis for individual programming. Instead, caregivers were provided with suggestions for activities which fostered development at different levels in the four areas of the DIAL (gross motor, fine motor, concepts, and communications) to use with their group as a whole. Caregivers were also given a framework of developmental stages to help them plan other activities appropriate for group abilities.

In addition, general programming suggestions were made for children who had difficulty with the DIAL but did not require referral. With children who had a diagnostic study and were discovered to have a handicap, the project staff also assisted with individual programming. The Ann Arbor School System, Division of Preschool Handicapped, was involved in programming when a child was referred to them after assessment. This agency did not seem to have adequate personnel or interest for more involvement. The Institute for Mental Retardation and Related Disorders at The University of Michigan provided a regular number of project-paid consultant hours for leadership and consultation in developmental assessment.

Social-Emotional Concerns

In keeping with our concern for the whole child, helping center and family day care home staff understand and deal with a child's social-emotional development was a consistent objective of the project. Our approach to this objective evolved slowly, and specific training and consultation objectives related to the social-emotional areas were different each year. Only in the third year did we develop objectives which met the areas of greatest need.

Objectives eventually specified that the project use two methods to assess social-emotional problems; the DIAL, which includes observations of behavioral factors in the assessment situation, and caregiver report. These were to be followed by project staff observation and consultation to the center. The project was also to attempt to integrate this consultation with project workshops on the social-emotional development of children and in other related workshops. These goals were met.

The objectives for each year also described the training and consultation team as including a social worker. Initially the role of the social worker in the comprehensive assessment process was difficult to define. However, as training developed, the social worker's emphasis on trust and relationship-building proved to make assessment, training, and consultation processes far more effective, and facilitated long-term follow-up.

The specific role of the social worker in training and consultation was first spelled out in Year II, and by the third project year, when the social-emotional areas of greatest concern to caregivers had been identified, consultation in these areas was directed by the social worker and was integrated into many aspects of project training: children's social-emotional development, parent involvement, staff relations, and staff-child interaction. In some centers, the skills of the social worker were also used to ease interaction between staff members, and between staff and parents, thereby helping to improve the day care environment.

Training and Consultation

Training and consultation were among the most vital areas of the project. By these means of technical assistance we hoped to improve the quality of care, aid problem identification, prevent problems when possible, and improve the continuity and follow-up of care for children.

By the third year, the project had developed an approach and techniques that successfully met our goals in these areas.

The general objectives of training were that it be interdisciplinary, be offered on-site where feasible, be related to individual day care center and family day care home needs, and be aimed at improving the program at the center or home. In addition, the project had as an objective the development of training materials that could be useful to the field. These goals remained constant over the three years of the project, and were successfully met.

For the second and third year of the project, additional specific goals were added regarding training content and format, and ways to achieve a focus for training in different centers and homes. In these years consultation was specified as part of training, for it became increasingly clear that effective training required consultation for follow-through.

Assessing Training Needs and Setting Goals

One of the first problems we tackled in meeting training and consultation goals was how to assess a center's training needs. We wanted to combine center staff and project staff judgements to make this assessment. To make our own judgments in the first year, an observation instrument was developed and administered. But project staff were uncomfortable in the role of evaluator since centers had never requested this assistance. By the third year a more satisfactory system had been developed. A needs assessment instrument was developed that involved the center director, center staff, and project staff: "The Caregiver Questionnaire" (Appendix A2). In its final form the instrument provided a picture of the relative skill levels and training needs of the entire staff.

After results from this assessment were gathered, goal-setting sessions were held with center staff and their project team. At this time the results of the needs assessment were discussed. Then project and center staff combined the assessment information with screening results and center and project staff's judgments about needs, and set initial goals for center training. Objectives in the area of needs assessment and goal setting were met only slowly, as project staff recognized that trust with the centers had to be established before learning could take place.

Training

The development of workshop training materials for use in the day care field was an objective that caught the imagination of project staff. These materials might have wide impact on preventive and developmental care, so a great deal of effort went into the development of each workshop. Some of the materials for the workshops were entirely original.

Early training materials were based on the four areas of the developmental assessment instrument: gross motor, fine motor, concepts, and communications. During the latter two years of the project these areas were broadened, based on the needs of the centers and the caregivers with whom we worked.

Contrary to our initial objectives, the time devoted to training in centers was short. We learned that training was not welcome in the summer because of staff vacations and turnover. Since the first project year did not get under way until January and screening wasn't completed until May, we could offer only a few basic training workshops in the first year. In the following two years assessments and follow-up took place from August through December. Consequently, the follow-through period of training became January to June--only five to six months rather than the eight months we had originally hoped to use.

Since the project was affiliated with a university, we had as an objective to serve as a training situation for graduate students. We had originally conceived of an experienced graduate student who, with the help of an interdisciplinary team, would become the primary trainer and consultant for a unit of day care centers and family day care homes. Because students lacked time and did not always have needed skills, we moved away from this idea. In the second and third year we devised more limited assignments for graduate students, and the most experienced granduate students became regular project staff members.

Because family day care homes did not, for the most part, become affiliated with nearby centers and did not take advantage of center-based training, in the third year our objectives specified that these homes would be a training unit by themselves. One education specialist was assigned as their primary trainer and consultant, with social work and nursing team members available for help as needed. An individualized approach to assessment of needs and different approaches to training were developed for the homes in this third year.

Follow-up

Follow-up in our initial objectives was to serve two purposes: to provide follow-through for health and developmental assessment referrals which had already been made, and to establish agency linkages for requisite referrals and follow-up procedures. Increasingly, however, follow-up permeated every aspect of our work, and our objectives were altered to meet this fact. Post-assessment, referral, and identifying resources to meet referrals became only the first step in follow-up. We began to use the interdisciplinary team to provide follow-up on a longer-term basis; this became the follow-through phase of project activities.

The advantages of the follow-through system were multiple. It allowed for ongoing identification of new problems, prevention of other problems, and longer-term case monitoring as it was needed. In addition, follow-through training allowed center staffs to develop their own skills while consultation gave them the support of a skilled specialist if the need for her services arose. Centers used project follow-through training and consultation for projects like developing health policies and monitoring children's health records in the center.

Record-keeping Systems

Only in the first year did the project have a specific objective about the development of a standard record-keeping system for the centers. We dropped this objective when it conflicted with our decision not to impose anything on centers they did not request. During our second and third years the project did present record-keeping as an effective way to secure follow-through, case management, and prevention during training and consultation. We also developed, and recommended for center use, a sample comprehensive intake form that included all of the historical health and developmental information about a child which might be useful to a center. By the third year most of the centers had adopted this form (Health and Developmental History Intake Form--Appendix A3).

To further promote record-keeping, the project drew up a prototypical health policy (available in the health training modules) which was recommended for center use in the third year. This included a record-keeping system and methods for keeping the caregiver abreast of children's medical conditions, treatment, and medication.

Final project record-keeping systems involved checklists. During consultation on children's problematic behavior, project staff often suggested recording children's behavior over time so that progress might be noted. Systematic behaviorial check lists were developed with two centers and a safety checklist was developed for all centers (available in the health training modules). A specialized observation checklist was developed for family day care homes (Appendix A16), along with individualized record-keeping systems to meet specific needs in some of the homes.

Parent Contact and Involvement

From its inception, project objectives stressed parental involvement. We required parents' knowledge and permission for all procedures involving their children. Information about the results of all screenings were sent, or given directly, to parents. In all of our training and consultation we stressed the importance of eliciting all information about a child from his or her parents and the necessity of planning and problem-solving with parents. We also promoted regular parent conferences, and where parent involvement was minimal we suggested increased family involvement as a possible center goal. While these suggestions were not always accepted, several centers made significant changes in working with parents based on project recommendations.

Initially the project planned to make contact with parents through the community coordinator, a paraprofessional project staff member who might be from the parents' own community. However we soon realized that parents' primary need was to be in close communication with center and family day care staff. So to better meet our goals for parent contact we began to act as an adjunct to center staff. We provided information they might share with parents and helped them to improve their skills and their will to communicate and work with parents.

When a child's problem called for referral to community resources, it involved a joint effort of center and project staff. Thus the project team member responsible for this often played an active role in the process and might have many direct contacts with the parent. Project staff also had direct contact with parents when they were requested by center staff to assist with parent conferences. Other direct contact with parents was through a booklet developed by the project, Big Hands, Little Hands Together (found in the project's replication materials). Its purpose was to widen parents' understanding of their child's development and it included suggestions for parent-child activities which would foster that development. A copy of this booklet was given to each parent whose child received the developmental assessment.

Human Service Agency Coordination

Our demonstration objective in the first year was to show the use of a multidisciplinary team serving day care centers, with members of that team coming from existing community agencies. In the second and third years this objective was more realistically stated. The team was to come from the project rather than from the community agencies, and it was described as "inter" rather than "multi" disciplinary to better reflect its activities. The team would seek close links with community agencies and would make the agencies aware of the project's methods and materials. The team would also compile information about the responsiveness of the community agencies to the needs of the children in day care. These second and third year goals were met.

Throughout the three years, the project had as a goal encouraging sufficient community involvement in project activities so that interdisciplinary services would continue when the project terminated. To meet this goal agencies had to learn more about day care while day care centers had to learn more about the resources these agencies had available. In the first year of the project, the EPSDT medical screening team from the Washtenaw County Health Department came to the day care centers for medical screening. The health department was also somewhat familar to and with the centers as it had been bringing vision and hearing screening to them. However, because of project coordination, centers began to coordinate health department services themselves, requesting assessment early in the school year when the greatest preventive work could be carried on, and the health department was responsive to these requests. Similarly, the project made centers aware that a public health nurse could be assigned to them if they requested it, although we were unsuccessful in our goal of having a public health nurse assigned as a regular member of the project team.

As part of our success in agency coordination, in the third year of the project a consultant from the community mental health agency was assigned to work as the social worker member of one of our teams. That person now has had first-hand experience with the interdisciplinary methods of the project and plans to replicate them. She will act as a nucleus for an interagency consultation team serving day care centers in the future.

Finally, the project worked closely with the Child Care Coordinating and Referral Service (CCCRS), which we saw as the appropriate agency to continue coordination of interdisciplinary consultation after the project ended. Project activities with CCCRS and other agencies has stimulated extensive interagency activity in the community and CCCRS has agreed to coordinate future interagency consultation services for young children and their families.

CHAPTER 3: THE POPULATION SERVED

The Day Care Centers

Six day care centers were originally involved in the project. At the end of the first year, one of these centers dropped out and four new centers were added to the project. By the end of the second year, two centers had closed and one new center was added. Thus, of the eight centers in the project during the third and final year, four were in the project all three years, three were in the project for two years, and one was in the project for one year. These additions and losses of centers did not represent drastic changes in the population the project served over the three years. However, the population description which follows will include information both for the initial year of the project and for the final year.

Organizational Status

Of the six first-year centers, two were private, non-profit organizations; three were public, non-profit; and one was private, profit. Of the centers in the project during the third year, four were private, non-profit; three were public, non-profit; and one was private, profit. On a county-wide basis, approximately 50% of the day care centers in the county were private, non-profit; 25% were public, non-profit; and 25% were private, profit organizations.

Years of Operation

The years of operation for the six first-year centers ranged from 1.5 years to 43 years; the bulk of the centers, however, had been operating for 3.5 to 8 years. For the third-year centers the years of operation ranged from 3.5 to 43 years (figures based on year of entry into the project), again with the majority of the centers falling within the 3.5-to 8-year range.

License Status

Five of the first-year centers were licensed to care for two-and-a-half to six-year-olds, while one was licensed for infants and toddlers from birth to two-and-a-half-years. Six of the third-year centers were licensed for two-and-a-half to six-year-olds, one for one-and-a-half to six-year-olds, and one for birth to two-and-a-half year-olds. The licensed capacities and actual enrollments for the centers are indicated below (figures based on year of entry into the project):

Center Capacities and Enrollments

	Licensed Capacity			Actual Enrollment		
	Total	Mean	Range	Total	Mean	Range
First Year	291	49	17--75	241	40	14-77
Third Year	391	49	17--88	369	46	14-90
County-wide	1650	46	15-100			

Enrollment

The enrollment figures above include some children enrolled part-time. Three of the six first-year centers were operating at or near their licensed capacities, as were six of the eight third-year centers.

Center Operation

All centers in both the first and third years operated Monday through Friday. All opened at or before 7:30 a.m., and all but one remained open until 5:30 p.m. or later. The one exception was a center serving high-school-aged parents which closed at 4:30 p.m.

All centers served at least a snack to the children. Of the first year centers, three served breakfast, lunch, and snacks; one served lunch and snacks (data missing for one center; infant center not included in these figures). Of the third-year centers, four served breakfast, lunch, and snacks; two served lunch and snacks (infant center not included).

Financial Support

All of the centers accepted DSS-supported children, since this was a requirement for inclusion in the project. (Approximately 75% of the day care centers in the county accepted DSS-supported children.) Tuition rates varied and sliding scales were frequently available, but rates did not exceed $45/week for the first-year centers and $40/week for the third-year centers. Other sources of funding mentioned by the center directors included Title XX, City Development Block Grants, the March of Dimes, United Way, U. S. Department of Agriculture (milk funds), and the state Department of Education child feeding program.

The Center Directors

First Year

Directors for the first-year centers had served in their positions for from one to three years (one director was an acting director; data from one center were missing). Three of these directors held bachelor's degrees, two held bachelor's plus master's, and one held an associate's degree, all in early childhood or related fields such as elementary education, psychology, and nursing. Two directors had public school experience, four had previous day care or early childhood experience, one had nursing experience, and one had community service experience.

Third Year

The directors for the third-year centers had served in their positions for from one to five years; of the four remaining original centers, two had a change of directors during the course of the project. One director held an associate's degree, one held a bachelor's, and four held bachelor's plus master's degrees. One director was currently enrolled in an early childhood program and one director had completed all but the dissertation for a Ph.D. (figures based on first- and second-year director interviews). Four directors had public school experience, six had previous day care or early childhood experience; and one had community service experience.

The Center Caregivers

The numbers of full-time and part-time caregivers are indicated below:

Full- and Part-time Caregivers

	Full-time			Part-time		
	Total	Mean	Range	Total	Mean	Range
First Year	29	5	0--8	17	3	0-8
Third Year	40	5	0-10	22	3	0-8

In addition, five of the first-year centers indicated they used volunteers; three indicated they used foster grandparents. Seven of the third-year centers used volunteers; three used foster grandparents. Many centers made use of practicum students from early childhood degree programs.

Caregiver:Child Ratio

Because of the varying combinations of full- and part-time caregivers and children and the various job classifications of teachers, assistant teachers, and aides, it was difficult to accurately determine the caregiver:child ratios. However, it appeared that for the first-year centers it ranged from 1:2 (for the infant center) to 1:9 and averaged about 1:5. For the third year centers it appeared to range from 1:2 to 1:12, and averaged just under 1:6. (The center with the 1:12 ratio had a large number of children who came only part time, so the actual ratio was likely to be much smaller than the figures suggest.)

Staff Turnover

Information concerning staff turnover rates was collected only during the third year of the project. Based on directors' estimates, the turnover rate averaged about 33% for the eight third-year centers, with a range of 15 to 50%. The turnover rate coincided reasonably well with the proportions of missing data from caregivers in the evaluation data over the three years of the project.

Education

Because of the turnover rate and because of differing decisions concerning which job classifications of caregivers to interview each year, accurate counts of the education levels of caregivers are not available. However, both the first- and the third-year centers had at least one full-time caregiver with a degree beyond high school or who was working toward such a degree. For one first-year center and four third-year centers, all, or nearly all, of their full-time caregivers held degrees beyond high school or were enrolled in degree programs; a few caregivers held master's degrees. The degrees generally were in early childhood education, elementary education, special education, or related fields.

The Center Children and Parents

In order to maintain confidentiality for the children and their families, no information about individual children was routinely collected other than that obtained through screening, which will be presented in Chapters 5 and 9. However, some information was available at the center level concerning the population served by the centers.

Although all centers accepted DSS-supported children, the actual proportion of DSS children differed from center to center. The means and ranges are presented below:

Percentages of DSS-Supported Children

	Total Population	Mean Center %	Range
First Year	45.6%	50.8%	25-80%
Third Year	41.5%	46.0%	25-80%

Parents

For the third-year centers (the following data were not collected the first year), the mean percentage of working parents was 81.5%, with a range of 50-100% (these figures do not include two centers which served only student parents). The mean percentage of student parents was 45%, with a range of 5 to 100%. For three of the third-year centers, the majority of the children they served came from the general neighborhood of the center.

Two first-year centers and four third-year centers served somewhat specialized populations. One first-year center, as indicated earlier, served children of high-school-aged parents; the other of these first-year centers served only children of single parents. Both of these centers were also in the project during the third year. Another third-year center served children of students at a local community college, and thus had a sizable number of children enrolled only part-time. In the fourth center about 50% of the children enrolled were handicapped.

Family Day Care

Five family day care (FDC) homes were originally involved in the project. At the end of the first year, two of these FDC homes dropped out and seven new homes joined the project, for a total of ten. At the end of the second year, five dropped out and three new homes were added, for a total of eight in the final year. Of the eight FDC homes in the project during the third year, two were in the project all three years, three were in the project for two years, and three were in the project for only the final year. The population description which follows is based on information gathered in the final year of the project.

Years of Operation

For the eight third-year FDC homes, the years of operation ranged from three to eleven years, and the bulk of the homes had been operating for five to six years.

Licensed Capacity and Enrollment

The licensed capacity of the five third-year FDC homes for which information is available ranged between four and eight children, without specification of the ages to be serviced. Enrollment figures included children who attended part-time, and the five homes operated at or near their licensed capacity.

Operation

All FDC homes operated Monday through Friday, but each FDC-giver had on some occasions taken children on an emergency basis for a weekend. The hours of operation varied, but usually extended from before-school hours to after-school hours, including several evenings.

Snacks were served in all eight FDC homes, and lunch was served to all children who were in a home during lunch hours.

Of the five final-year FDC homes for which information was available, three, or 60% would accept DSS-supported children. This was not a requirement for FDC homes to join the project.

The Family Day Caregivers

One FDC-giver in the final project year had an associate's degree in early childhood, and two were attending classes in early childhood education. The remaining five FDC-givers had experienced a variety of informal training such as on-the-job training as a teacher's aide (2); attending conferences (2) or workshops (5) on day care; and their own self-directed reading. Related experience was as a parent (all), a Sunday school teacher (1), and as a day care center teacher (1).

Assistance to the FDC-giver varied. Four had their own children's help after school hours and had the help of adults in the family (including three fathers who were licensed as FDC-givers). When substitute caregivers were needed, FDC-givers contacted people who were friends and had previously exchanged services.

Because of the varying hours children attended, it was difficult to estimate the caregiver:child ratio. For five of the final-year FDC homes, the ratios ranged from 1:3 to 1:8, with a mean of 1:4.

The Family Day Care Home Children and Parents

The children in the FDC homes ranged in age from infancy to elementary school age, with preschoolers representing the largest population (43% of the total). The total number of children in the eight homes was 42, the number in a single home varied from two to ten. The mean was five children in the five homes for which information was available. The proportion of DSS-supported children in these five homes varied from zero to 33%.

For five of the eight final-year FDC homes, the mean percentage of working parents was 87%, with a range of 75%-100%. The mean percentage of student parents was 13%, with a range of zero to 25%. In five of the eight final-year FDC homes, 60% of the children came from the general neighborhood of the home, with a range of 33 to 100%.

CHAPTER 4: INTRODUCTION TO THE INTERDISCIPLINARY AND COMPREHENSIVE APPROACH

Part II of this report describes the approach, methods, instruments, and processes developed by the interdisciplinary staff of the project to provide comprehensive assessment and follow-through for young children and their families. Since the project was both a research and a demonstration effort, we dedicated considerable time to validating our assumptions and establishing a framework from which to work. We also spent time developing approaches and materials to meet our goals. Some of our products have now been refined to the point that we recommend them as they are; others we believe need still further work. All of the methods and materials we developed work best if they are adapted to meet the special needs of the persons for whom and the community in which they are used.

Overview

The project's initial concern with health and with enhanced EPSDT services led us to explore broadening the health services available to young children and their families. In considering goals for a wider range of services, the project worked from three assumptions: first, that most health problems could be corrected or eased by providing children with broader health services; second, that children's health is an interrelation between physical, developmental, social-emotional, and environmental elements; and third, that if the project improved the overall health of children, both human stress and money spent on health care would be reduced in the long run.

Based on our assumptions and on our evaluation of services available, the project developed three major goals for improved health services: to provide clearly defined comprehensive health assessment rather than just screening for children; to expand health services available to the children assessed; and to link service providers so they could coordinate their assessment and follow-up procedures to reduce fragmentation and duplication in service delivery.

The project saw day care as a viable means of reaching these goals. We developed methods to expand the role of day caregivers so they could provide for comprehensive health assessments for children in their care. We also provided services and training so caregivers could adequately follow up assessments with any needed services. This method demonstrated its benefits: it ensured that children received follow-up for problems identified during assessment and health care attention for problems which arose between assessments. It also provided a channel for coordinated outreach by community service agencies which allowed them to increase their preventive services for young children with little increase in cost. The approach also allowed agencies to return to a secondary support role for families, giving the primary support role to day caregivers--the people closest to the family in its daily activities.

Interdisciplinary Methods

"Interdisciplinary" has several meanings, and the interdisciplinary element in our approach has evolved through several of them. The project began with separate disciplines working along side one another--something of a multidisciplinary approach. By the third year, the staff had been reorganized along more interdisciplinary lines. Interdisciplinary staff members worked together as a team of generalists for most projects, but called on skills from their individual disciplines as they became necessary for specialized training and information. This approach was a way to build on the commonalities that the disciplines shared and to use most efficiently the practitioners' shared and specialized skills.

This interdisciplinary approach was essential in two major project thrusts: programming and coordination. Programming dealt with the immediate delivery of services to the child and his or her [illegible]. In coordination efforts the child's relation to his or her whole environment (home/center/community) was of concern. Interdisciplinary programming in this area allowed us to, for example, have an increased awareness of the relationship of physical problems to social-emotional behavior concerns, and to have integrated skills and resources immediately available to remediate problem situations.

The second major use of the interdisciplinary approach was in its implications for interagency coordination. It allowed us to deliver services with qualitative efficiency and to effectively utilize the specialized skills of providers from various agencies.

To meet the demands of interdisciplinary programming and coordination, the project developed teams composed of a nurse, a social worker, and an early childhood education practitioner. Each team of three specialists was aided by a team assistant who recorded and distributed team minutes, kept files up to date, did groundwork and research where necessary, and gave general assistance in assessing and preparing training activities.

All three consultants on the team were in the centers bi-weekly; one team member, designated as a liasion, was responsible for communication with and between the center, consultants, and parents. This person was instrumental in clarifying expectations between project and day care staff and in building the trust and open communication basic to an effective program.

The interdisciplinary teams met every other week to discuss plans for individual centers, based on the center's phase of activity. The team made referral and follow-up decisions for individual children during the center's assessment phase, and consultation and training plans during follow-through. In the weeks between interdisciplinary meetings, staff members from individual disciplines met to discuss issues relevant to their discipline. Both team and discipline meeting minutes were distributed to all project staff, and team and discipline coordinators oversaw efficient referral of interdisciplinary matters. This cross-reference system ensured effective interdisciplinary planning and follow-up and allowed us to develop interdisciplinary materials and instruments. These immediate benefits of our interdisciplinary approach were invaluable, and our experience suggests that the long-term advantages, which cannot yet be measured, are equally beneficial.

Procedures and Instruments

Project activities can be broken into two major phases. Each of these phases can be further broken down into the stages in which the interdisciplinary methods and instruments developed are implemented.

Phase I: The Comprehensive Health Assessment Process:

Stage 1: Parents fill out the Health and Developmental History Intake Form and discuss it with a day care staff person. The form is one developed by the project and adapted by each center to meet its needs (Appendix A3).

Stage 2: Medical screening is provided for the children. (For optimal and efficient participation, the project recommends this be done on site.) This includes the EPSDT protocol and dental screening (or a modified screen in accordance with particular needs of a specific community).

Stage 3: A comprehensive developmental assessment is administered on-site by day care staff and practitioners working together, for each child whose parent has given permission. The Developmental Indicators for the Assessment of Learning (DIAL) was the assessment instrument used in this stage.

Stage 4: Feedback sessions are held between day care staff and project staff to integrate the information obtained from the health assessment process and from observations. Plans are made for groups of children and for individual children for whom there is concern.

Stage 5: Follow-up takes the form of communication with parents, individual referral, monitoring of referrals, training, consultation, health and safety policies, and records (see model Health Policy in Health Training Modules).

Phase II: Technical Assistance--Consultation and Training:

Stage 1: The comprehensive health assessment process of Phase I continues. There is continued observation for children with special needs, the intake form is provided to newly enrolling parents, there is continued monitoring of referrals and program plans, and health and developmental assessments continue to be available.

Stage 2: The Caregiver Questionnaire is provided to caregivers, directors, and practitioners to assess needs for further training and consultation. The questionnaire is a comprehensive instrument developed by the project's interdisciplinary staff with the assistance of the evaluation team (Appendix A2).

Stage 3: Mutual goal-setting sessions are held between project staff members and day care staffs during which information from the health assessments, the caregiver questionnaire, observations, and caregiver ideas about their training needs are integrated. Goals are agreed upon and training and consultation plans are made for implementing the goals. Goal-setting sessions should be held periodically to reassess previously set goals and accomplishments, and to reset goals when necessary.

Stage 4: Interdisciplinary consultation and training sessions are provided at central locations for basic and common issues, and on-site at day care centers or in day care homes to meet special individual goals. (Training materials developed by the project are in three sets of modules: Health, Social-Emotional, and Curriculum.)

> Stage 5: Continuous observation and follow-up for individual children for whom there is concern and ongoing consultation with day care staff provide follow-through and implementation of plans for children and day care staff. This is an ongoing means of case-management support for day care staff.

In chapters six through eight, the development of this comprehensive and interdisciplinary approach to child health assessment; the training and consultation necessary to assure its follow-through; and the project's service methods, instruments, and findings, are described in detail.

CHAPTER 5: HEALTH ASSESSMENT AND FOLLOW-THROUGH

Overview

The project developed methods and tools for comprehensive assessment of child health that were in tune with its emphasis on an interdisciplinary and whole child approach to health care. In the project's assessment, the social worker, nurse practitioner, early childhood educator, caregiver, and parent work together as a team. This chapter will describe in detail how this team functions, and will describe the tools and methods they use to provide health and developmental assessment and follow-up. Case examples showing the value of an interdisciplinary approach to screening and follow-up, are also provided.

Health and Developmental History Intake Form

Rationale

The Health and Developmental History Intake Form (see Appendix A3) grew out of the project's desire to help caregivers look at the whole child when he or she enters care. Some centers already had a way of gathering some of the information needed, others did not. All centers needed help in interpreting the information they collected.

Each center had input into the design of the form. Consequently, when it was finished, centers readily accepted and used it. The questions on the form drew together physical, social-emotional, and cognitive information about the child's growth from prenatal development to the present, and so could, if carefully used, indicate areas of potential concern about a child. The form served a number of other purposes as well. It provided a way to have available in one place, all the health, developmental, and social history the center needed to begin to understand a child. including some critical observations by the parent of the child. The form also provided some continuity between the home and center by necessitating parental involvement in the initial assessment process: it ensured that caregiver and parent would share pertinent historical and current information in their mutual concern for the child.

Design

The Health and Developmental History Intake Form pulled most items from individual centers' intake forms and pulled a few items from the State Department of Social Service Health Screening Summary. These items were then submitted to centers for tailoring.

The form was divided into six sections: basic family information; health and developmental history; nutrition; social behavior; and parents' interests. A center serving only single-parent families tailored the family information section to gain more understanding of where the child stays when not with the parent. The nutrition section allowed day care staff to determine food preferences and eating styles, since many Ann Arbor families come from minority cultures or prefer to eat natural foods. The social behavior section helped caregivers understand a child's insecurities and fears, as it included information like the best way to awaken the child from a nap and the child's previous separation experiences and behaviors under stress. The section on parents' interests encouraged the parent to assess his or her expectations for the child's experience in the day care setting and to discuss them with the caregivers.

Most centers responded very favorably to the intake form, having previously had only a limited form or no form at all. There was concern from a few centers that the form was too long and might seem like another bureaucratic piece of paper to parents. We suggested these centers present the form as an expression of their very real concern about the child coming to the group care situation, explaining to parents that staff members wanted to get to know the child and knew the parent had valuable information that would help the center provide the best environment for the child. All but two centers have used the intake form. The project has not heard any negative feedback on it, and has witnessed its advantages when it is used as part of the larger interdisciplinary and comprehensive assessment process.

Implementation

Some centers used the intake form only for new families, while others used it for all families enrolled in their program. The project processed forms from all centers in the same manner. When forms were completed, the nurse practitioner on the assessment team reviewed the information received. She then synthesized the information and condensed it onto a health supervision checklist which was stapled inside the front cover of the child's progress folder (Appendix A4). This checklist was filled out when the child's records were first received and at update times thereafter.

When all steps in the health and developmental assessment process were completed, a feedback session was held for caregivers. In this session the child's historical information was tied with present health and developmental information, and caregivers received some training in interpreting the information gathered. Centers were encouraged to use public health nurses to aid in this intake and interpretation process after the termination of our project.

Medical Screening

Use of EPSDT Protocol

The state of Michigan, "EPSDT Protocol for Children Under Six" was used as the basis for our screening of children. This states:

> The screening requires the following components:
>
> Every child must be accompanied by a parent, guardian, or adult relative.
> Completion of a Health History Form including immunization history, by a parent or guardian.
> Hearing screen--all ages
> Vision screen--over age three
> Denver Developmental Screening Test
> Height and weight
> Blood pressure--age five and up
> Hematocrit (test for anemia)
> Sickledex Test for sickle cell trait
> ZPP technique screen for lead level in blood
> Urine test for sugar and albumin
> Unclothed physical inspection by nurse
> Conference between nurse and parent for interpretation of screening tests and referral if needed
> Parents may receive a routine written EPSDT report of Health Screening Summary.

First-Year Screening

The project varied the EPSDT protocol, using slightly different methods during each of the three project years. In Project Year I:

1) The DIAL was substituted for the Denver Developmental Screening Test (DDST), and was done at a different time than the rest of the screening.

2) The usual hearing and vision screening service provided for day care centers in Ann Arbor was substituted for the EPSDT hearing and vision screen (technique and technicians were the same).

3) The rest of the EPSDT protocol was done on-site at day care centers jointly by project and EPSDT staff.

4) Prior to screening, project staff made a concerted effort to educate day care center staff about the EPSDT

screening process and to make sure parents were educated so they were giving informed consent. Letters, parent meetings, and individual meetings were all used with parents. All parents signed a permission form before appointments for EPSDT screening were made. (A copy of the letter may be found in Appendix A5.)

5) Also prior to screening, day care staff helped prepare children for the assessment by demonstrating the use of real equipment, integrating health units into their programs, etc.

6) Most, but not all children, had a parent present during the screening. Where work commitments prevented the parent's attendance, screening was not denied; with the parent's permission a caregiver served as a parent surrogate.

7) Parents could request that only certain specific tests, perhaps those not available to them at their child's last physical exam, be done. Sickledex testing for sickle cell anemia was often requested in this manner.

8) All parents were given a copy of the health screening summary report to keep and a copy was placed in their child's day care center health file. The health department does not routinely give parents a copy of the health screening summary.

Using these methods, in the first year we were able to screen 39 percent of the population in the day care centers served by the project. Forty-five problems were found. In addition, the examinations provided day care directors with direct feedback on the health concerns of their children, and provided parents with a written record of the screening so they could assist with continuing health observations. There was only one major problem with first year screening: scheduling problems for hearing and vision screening made the integration of this information in feedback difficult. And since hearing, vision, and dental referrals are most common with EPSDT, it seems reasonable to conclude that if feedback and referral had included hearing and vision results, they would have been more effective. The numbers and types of problems found in the first-year EPSDT health screen are charted in Appendix B4.

Several factors lowered the numbers of children screened and recorded. The project got off to a very late start the first year, so that the screening could not be coordinated with fall enrollment. And children who did not have every test in the EPSDT battery were not counted by the Health Department as having participated in the screening. Further lowering participation numbers, the Health Department would not provide additional on-site screening over the year, either for children new to the center or for children of parents who wished to have screening done after learning more about its benefits from others. Finally, the issue of trust affected participation. Washtenaw County is a highly researched community because of The University of Michigan. Consequently, in our first year of working with centers and parents, we met with much anxiety over the screening and research to be done by the project. However we worked with center staff and parents over the three project years, more trust and acceptance grew. And by the second year we saw caregivers valuing the screening and encouraging parents to participate.

Despite our first-year difficulties, the on-site screening was far more efficient than screening methods used in the second and third year. The on-site clinics could be, and were, well organized--with personnel, equipment, parents, and children scheduled and ready--so that the actual screening time required for six centers was only twelve days.

Second-Year Screening

In Project Year II, other variations from standard Michigan EPSDT screening and variations from first-year practices were made:

1) The complete EPSDT screen was offered at the county service center three-and-one-half days per week, and children could receive the tests only with a parent, guardian, or adult relative present.

2) The DIAL was given at the centers.

3) Three questions were asked to supplement the medicaid health history form (Appendix A6).

4) Screening was offered by group appointment, and the project provided transportation to the service center if it was needed. A center caregiver and a project staff member (the community coordinator) accompanied each group of seven children and their parents. Occasionally parents met their child at the service center, went through the screening, and returned to work. A project nurse was present at the screening to meet parents and help arrange referral appointments as needed.

5) Prior to screening, day care staff and parents were informed about the EPSDT process. Parents signed a permission slip before a screening appointment was arranged for their child (Appendix A7).

6) Also prior to screening, project staff met with day care staff to present ways to prepare children for screening,

using health programs and a health kit which included a Creative Playthings stethoscope, urine cups, fingerprick equipment, and tongue blades. Hearing and vision deficits, nutritional anemia, and dental caries were also discussed at length with staff members because these are areas where modification in day care center operation can alleviate problems.

7) All parents were given a copy of the Medicaid Health History Form (Appendix A6) and the Report of Health Screening Summary (Appendix A8) and were asked to provide a copy of each to the child's center. The project would copy summaries if needed.

8) Screenings for non-medicaid clients were paid for by the project. Approximately one-third of those families participating in the screenings were medicaid-eligible.

With these second-year methods, 44 percent of the project population were screened. More problems were found (90) than in the previous year, mainly hearing and vision problems, dental caries, and immunization updates. We informed day care staff of any significant findings requiring follow-through and we discussed how they could assist children and their families to obtain services. The number and types of problems found via the EPSDT health screen for the second year are charted in Appendix B5.

The method used in the second year was fraught with disadvantages. It was highly inefficient. It took many weeks and made inordinate demands on project personnel time as it necessitated considerable duplication of effort. Screening the second year required four months (November through February) at three-and-one-half days per week to get through eight day care centers. A further disadvantage of this method was the difficulty in providing safe transportation for young children in winter travel conditions.

Third-Year Screening

During the third project year, further changes in the screening system were made.

1) The Health and Developmental History Intake Form was filled out by the parent at the center.

2) EPSDT screening was done directly through the EPSDT clinic.

3) Parents were informed of the service by the project or the center staff. Parents received an information packet in the mail which included instructions for

making an appointment, travel directions, permissions, etc. (Appendix A9).

4) Parents were responsible for their own transportation.

5) No project staff were present at the clinic during screenings.

Using the standard EPSDT clinic approach but offering the service to our expanded population, 16 percent of the project's population were screened. Most of the families who were screened were non-medicaid-eligible. Referrals were most frequently made for hearing and vision problems and dental caries.

Although in the third project year health screening was available earlier than in previous years, there were barriers to its being widely used. One center in the project was new the third year. Consequently, we had limited time to build trust and communicate the advantages of the health and developmental assessment to this center. As a result, center staff did not adequately pass out information materials to parents, nor did they actively seek permissions. No children from this center received the medical screening at the county service center. Lack of transportation, in general, was a barrier for parents from all centers. Also, during the time that day care parents were attempting to schedule appointments, DSS changed phone numbers, and, additionally, was short staffed, so that a passing secretary often answered the phone. As a result, many prospective clients were thwarted by being unable to reach the appointment desk, by being misinformed, or by being turned away. The number and types of problems found via the EPSDT health screen in the third year are charted in Appendix B6.

Hearing and Vision Screening

In addition to the EPSDT screen available at the county service center, in the third year the project aided hearing and vision screenings done at the day care centers. The hearing and vision screen on site at day care centers is a service already offered to most day care centers in Washtenaw County, so the project did not establish screenings except in the third year, when we discovered that one center had been missed for several years. The project was primarily involved in getting children screened--making sure parents knew the dates for hearing and vision screening and encouraging them to have their child in the center that day--and in consulting with caregivers about the results of screening.

There were two barriers to optimal use of the hearing and vision screens. First, although most centers were given a pick-up day when children who had missed the regular screening could be tested, not all children were screened. Children were missed when screening was done during the summer or when they attended day care only part-time. Second, screening results that indicate a hearing or vision deficiency are most useful to the child, the parent, and the caregiver early in the school calendar year. If detected early, corrective measures can be taken and special adaptive programming and child care approaches can be developed. Unfortunately not all children could be screened in the early fall.

Despite these difficulties, many problems were detected. For the combined referrals made by the health department and the EPSDT clinic, hearing referrals were most common. In this third year, nineteen hearing problems were found in our population, only one of which was already under care.

Project consultation about hearing and vision screens involved educating caregivers to think of hearing loss as a possible cause for a behavior problem, a short attention span, etc. During consulation we also explained how to use individual hearing referrals for children whose hearing caregivers questioned, since several of the teachers were very accurate in detecting children with hearing problems.

Dental Screening

The project arranged for six of the centers to have on-site dental screening done by The University of Michigan Community Dental Health Mobile Unit. The seventh center had already made arrangements for this service and the eighth center enrolled children too young for screening. In two days, 147 children were screened at the six centers. The cost of dental screening for centers was $25 per day which covered the exam and a letter for centers and parents which explained the service and listed local dentists (Appendix A10).

Fifty-four children examined in this on-site dental screen had some dental need. The parents of the children who had moderate decay were alerted and these parents were called later to see if they had followed through with a dental appointment for their child. Parents of children whose dental screen indicated a need for immediate dental care (and who remained in a project day care center) were contacted until the child received care. The project was unable to follow up children who left the center or left town, with the exception of those who returned to day care after a period of months or switched to another day care center in the project. The numbers and types of referred problems from the third year dental screen can be reviewed in Appendix B7.

Overall, the response to dental screening was good. There was little center disruption and parents were enthusiastic about the service. The drawbacks were, again, timing and attendance. Children who were not present the day of the screening were not screened. Part-time students in centers where screening went slowly were sometimes passed by, and children who were reluctant were not screened. The dentists found children who attended day care full-time every day to be least reluctant and easiest to screen.

Both day care staff and dentists agreed that children must be prepared for a dental screening exam. Project staff found that providing caregivers with a detailed explanation of the exam and giving them the tools (explorer, mirror, tongue blade) for children to see and touch, was excellent preparation. Caregivers could then adapt the information to their own teaching style and to the needs of the children as they perceived them. The dentist from The University of Michigan School of Dentistry/Community Health Unit suggested that future dental screening be done in the day care center itself, using a regular chair and ordinary lighting. This would further reduce the strangeness of the screening for the children.

The dental school is willing to examine children in the centers they screened for the project after the project has been terminated. Centers can also have the services of dental hygiene students to teach preschoolers good dental hygiene. Centers might follow up this teaching by providing for regular toothbrushing after eating, and by offering snacks that least promote dental caries.

For centers wishing to establish a dental screening and follow-up program, a health consultant who provides information and demonstration tools for dental screening, and a dentist or dental hygienist to do the actual screening, would be essential. A public health nurse is a resource for dental health teaching and dental screen preparation as are dental assistant students or dental hygiene students from a local community college or university.

Developmental Assessment

Instruments

The project relied on three developmental assessment instruments. The first is the Denver Developmental Screening Test (DDST), which is included in the EPSDT protocol. Specialists consider the Denver to be an unreliable instrument when used with children under thirty months of age, and, because of the small number of items and the extent to which the instrument relies on parental report, identification of older children with problems is also unlikely using the DDST. These findings correspond with project staff observations. The experience and training of the technician administering the DDST, both in working with children and in obtaining accurate developmental information from parents, probably also affects the reliability of the results. However, despite its many shortcomings, the DDST was the only instrument we could find which was designed for use with children under thirty months, so we used it.

The Developmental Indicators for the Assessment of Learning (DIAL) is somewhat more reliable. The DIAL is a developmental assessment instrument for 2-1/2 to 5-1/2-year-old children. It takes twenty to thirty minutes to administer and has a larger number of items which are more specific than the DDST, thereby allcwing a more comprehensive developmental screen. The DIAL can be administered on-site by trained assessors, so results are not based on parental report. And of the four assessment stations needed, two can be covered by caregivers from the child's center trained in a DIAL area. Thus children being assessed can remain in a familiar place with familiar people, but still receive fairly reliable assessment.

The DIAL does have some shortcomings. Its standardization is not optimal for our population and it includes several questionable items. However, on the whole, project staff decided that it was more reliable and provided more information than the DDST, and the DIAL was used for most of our population.

The DIAL is not a diagnostic tool. It is designed to assess four areas of development: gross motor, fine motor, concepts, and communications. A cutoff score is provided to indicate whether or not the child is in the bottom ten percent in any area as compared to children of the same sex and age. The criteria for referral, according to the DIAL's authors, is scoring below the cutoff point in any three areas or in communications alone. Preliminary research has indicated that attention should also be paid to children scoring below the cutoff in both fine motor and concepts, as this may be a predictor of difficulty in school performance.

A third instrument, in addition to the DIAL, was used for Kindergarteners. Because these children are at the top end of the DIAL's age limit, we were concerned we might not obtain enough appropriate information on them from the DIAL. So for these children we administered the Screening Test of Auditory Comprehension of Languages (STACL) as well. Only one child was found to be below the cutoff for the STACL and he had already been found to be down by DIAL criteria.

Parental Permission

It was necessary to secure parent permission before any developmental assessment was done. There was reluctance on the part of many parents, center and home staffs, and center boards, to accept developmental assessments of their children. They were concerned about issues of labeling and confidentiality, issues which had also been of concern to project staff. However, since the only information that scores on the DIAL provide is whether or not the child is in the lower ten percent as compared to the norming sample, and the instrument is not diagnostic, labeling is not possible, nor is ranking or the further categorization of children. We informed parents and staff of this, and assured them that all records, including DIAL score sheets, were number-coded--they would not have the children's names on them--and that the master code lists would be destroyed at the end of the project. In spite of these guarantees the project met with skepticism. But experience proved to be the best validation for the usefulness of the assessment. Confidence in the process and in the team administering it grew each year, so that in the second and third year day care staff actively sought parental permission for developmental assessment of those children for whom they had specific concerns.

DIAL Training

As important as the assessment instruments used are the skills of those administering them. Since two or four staff members from each center would assist project staff with DIAL administration, we conducted thorough training sessions prior to DIAL administrations. Each one-day session provided training specific to one DIAL area, but training was primarily directed toward principles of assessment and a general orientation to the DIAL. Training review sessions were available immediately prior to administration of the DIAL at each center, and an educator from the project was regularly available to further insure consistent administration and scoring of the DIAL.

All center staff members were invited to participate in on-site orientation sessions for the DIAL one week prior to its administration. These sessions were designed to acquaint the staff with the uses and limitations of this type of developmental assessment. In addition, all assessment items were demonstrated and, where appropriate, their rationale was discussed.

Our original intent was to ready each center to procede with DIAL screening independently after termination of our project. We planned to teach caregivers how to use the DIAL and how to secure the materials necessary for administering it. However three years of experience showed us that an additional step was necessary. To ensure more standard administration of the DIAL and to provide continued assistance in interpreting results, outside consultants were needed. Therefore, in the third year the project trained personnel with relevant academic backgrounds from the interagency child and family consultation network, to assist day care centers. These consultants will be coordinated by the local Community Child Care Referral Service (CCCRS), after termination of our project.

The project's experience with the DIAL has shown it to be of value to day care centers. Our administering procedure, combining day care and project staff, was also valuable. It gave opportunity for experiential training as well as trust-building, and it facilitated assessment of children who entered day care mid-year.

Findings

The percentages of children who received the developmental assessment over the three years were 47 percent, 71 percent, and 62 percent respectively. Third-year participation was a bit lower than second for two reasons: some parents were not interested in having their child screened a third time; and one center, new to the project, had not passed out materials to parents in sufficient time to gain permission for screening.

The percentages of children found to be down by DIAL criteria increased from 5.3 percent to 6.4 percent to 9.2 percent in the three years of the project. The higher percentage in the third year probably reflects several factors: the assessment was done earlier in the year than previously; caregivers had learned the value of the developmental assessment and were actively seeking permissions from parents of children for whom they felt concern; and, overall, the project teams and center staff were monitoring problems more closely.

The major cause for the higher proportion of children receiving the developmental assessment than receiving the health screening, was the on-site availability of the assessment. The number, percentage, and type of problems found among children developmentally assessed for each of the three project years are set down in detail in Appendices B1-3.

Use of Assessment Results

Project staff found that, coordinated with ongoing caregiver observations, the DIAL was a useful tool for cross-checking concerns; it helped identify children who needed further evaluation. Staff also found that when individual assessments were collated for each group of children, they could provide caregivers with a valuable picture of the strengths and weaknesses of their group as a whole. This data proved to be of assistance to caregivers in program planning.

The criteria, set down by the DIAL authors, for making referrals for further evaluation, are fairly clear-cut. But project staff preferred to rely on information from a variety of sources for referral. The DIAL results were considered with findings from the Health and Developmental History Intake Form, with any health information available, and most importantly, with observations by the caregiver. Information from people who are with a child as much as ten hours a day is invaluable in making referral decisions. Caregivers were asked if the DIAL results made sense to them. If not, they were asked to take special care to observe the child in areas in which he or she was indicated to be down, and after several months the DIAL would be readministered. Most often the caregiver did think that assessment results made sense. In these cases, possible referral sources would be discussed with the day care staff and the child's family.

Using the assessment results as we did allowed us flexibility in referrals. Referrals were not recommended where screening information was inadequate or when the knowledge of the child's background indicated that it was inappropriate (i.e., family in crisis). On the other hand, where the child's DIAL score did not warrant referral but other factors did, referral might be recommended. Most often these were cases of children whose behavior--distractable, disruptive, withdrawn--had been a concern in the group care setting and was also observed during the assessment. In these situations the developmental assessment was used as an added source of information to back up caregiver concerns. Children who were down in both motor areas or who were down in fine motor and concepts, might be referred or might only be closely observed for possible future referral.

DIAL Feedback

Feedback sessions were held with the caregivers at each center to discuss the results of the developmental assessments. Caregivers received a copy of the Individual DIAL Profile (Appendix A11) for each child assessed. On the profile, charts showed scaled scores on individual items (i.e., gross motor), color-coded tallies indicated the child's developmental age, and graphs charted performance in the four areas of the DIAL. Where children seemed to be experiencing difficulty, project and center staff appended a jointly-written comment to the profile.

This information was considered with information gathered from the Health and Developmental History Intake Form (Appendix A3), from the medical screening, and from the caregivers' own experiences with the child. (Since the comprehensive screening process includes no formal social-emotional assessment, parent and caregiver observation in these areas is critical.) Based on this information, project and center staff jointly decided which children's results warranted a parent conference. Also during feedback sessions, project staff urged caregivers to consult them about other children for whom caregivers felt concern: children who either had not been DIALed or whose problematic behavior did not affect their DIAL screening. During the feedback sessions, centers were also provided with room-by-room group performance profiles so DIAL results could be used for group as well as individual programming (Appendix A12). The profiles were color-coded to indicate children's ages.

Parents were included in the DIAL feedback process. To accommodate work schedules, and because on-the-spot results were not given, parents were not required to be present during the DIAL screening as they were during the EPSDT screening. From four to six weeks after the developmental assessment, a copy of the individual DIAL profile with an explanatory cover letter was mailed to parents (Appendix A13).

Since the project viewed screening as only the first step in looking at and working with children, we also published a booklet called, Big Hands, Little Hands Together (replication materials). In the first year this booklet included only an explanation of the assessment process. But in the second and third year activities which promoted the skills assessed in the DIAL were added. Activities were chosen which did not require a lot of preparation and which could take place in waiting rooms, long lines, and as part of the daily routine as parents talk, play, and work with their children. Each family who participated in the developmental assessment received a copy of the booklet, as did all caregivers. When children were down in one or more areas, particular activities in the book were recommended for them.

DIAL Assessment Results

In general, children scored high in the concepts and communications areas of the DIAL, while their motor development scores tended to be spread. These results are consistent with center programs that place value on cognitive and language skills and tend not to focus on motor skills.

In the second year of the project, DIAL testing revealed an unusually high number of children down in the gross motor area only. We used this finding as a starting point for discussion during training sessions on programming to develop gross motor skills.

In the third year of the project we found an unusually high number of children down in fine motor skills. We attributed this to our early schedule for assessments that fall; children had not been in the center long enough to experience many of the activities that develop fine motor skills (i.e., cutting, pasting, drawing, etc.). DIAL assessment data compiled over the three years can be reviewed in Appendices B3 and B19.

Interdisciplinary Case Management and Follow-through

The interdisciplinary team follow-up on problems raised during assessment was basic to the project's goal of health care for children. From the Health and Developmental Intake Form, the assessments, and caregiver observation, the team followed up with recommendations for appropriate programming and referral as needed. Also as part of the follow-through phase, the team set up case management procedures to draw together fragmented services and to reduce resource duplication.

Five Case Examples

A thorough picture of the numbers, problems, referrals, and types of follow-through action taken in response to the project's child health assessment activities can be reviewed in Appendices B1-21. But the five cases described here illustrate the role of the interdisciplinary team in the follow-up process:

1) Helping caregivers compile information about a child to better understand the child in relation to all influences on his or her growth;

2) Providing training, support, and consultation for conferences between parents and caregivers;

3) Dealing with referral problems like parent denial of need or refusal to seek treatment, or arranging for specialized help to interpret findings;

4) Coordinating services to best meet the child's and family's needs.

The first case illustrates the team's care in consulting all possible sources of information to gain a picture of the whole child. This child was a passive, nonspeaking three-year-old who tested down in three of the four DIAL areas. The child's doctor was called: he had not been concerned at the 2-1/2-year-old visit, but had made a note to make a more thorough neurologic appraisal at the child's next well-child visit. On the Health and Developmental History Intake Form, the mother indicated concern for her child: the parents had been involved in an unhappy marriage and bitter divorce at the time of the child's birth. The mother agreed to have her child retested after several months to determine if referral would be required.

The second case illustrates the team's role in helping caregivers work with the parents of children in their care. It involves a three-year-old child with an unremarkable developmental assessment and a benign health screen. He was noted on the Health and Developmental History Intake Form to be the only child of a recently-divorced 38-year-old mother. At birth the child had received a complete blood transfusion and had been hospitalized in intensive care for one week. In response to the question, "How do you discipline your child?" the mother had written, "I scream, I curse, I yell, I hit, I need help."

The team stepped in to help caregivers prepare for a forthcoming conference with the mother. The nurse on the team explained the birth history and its possible consequences for the mother and child. The social worker discussed the kinds of problems the mother appeared to be facing. Together the team and caregivers planned goals both for the conference and for future interaction with the mother and child:

1) Recommend to the mother a pediatrician known to be helpful to single parents. (The mother was new in town and had asked for the name of a pediatrician.)

2) Recommend that the mother attend a single-parent support group.

3) Continue to be supportive, open, and available to the mother.

4) Focus on praising positive behaviors of both the mother and the child.

The third case demonstrates the ways in which the team obtained specialized help or referral for a child. This child was down on the developmental assessment in gross and fine motor development. While this finding did not in itself indicate a need for referral, it was reinforced by the caregiver's concern. The caregiver had noticed that the child seemed uncoordinated and often fell on the playground.

The team began by compiling all available information on the child. Her health history from the Health and Developmental History Intake Form showed that she had had meningitis in her first year of life. The team nurse and the caregiver talked with the child's mother who also expressed concern about the child's progress. The mother said the child's pediatrician did not think there was a problem, although the child had a slight hemiparesis.

After integrating all of this information a conference was held with the mother, during which caregivers suggested that further evaluation of the child be done. The team also called in an occupational therapist to observe the child in the center and to recommend activities to the caregivers that might improve the child's fine and gross motor skills.

The fourth case demonstrates the value of the interdisciplinary team in helping day care staff to observe children more closely and to bridge gaps between the home and the center. The child was found to be down on the DIAL and had been very withdrawn and silent when the assessment was done. Checking the child's family background and caregiver observations, the team discovered that the family had recently come to this country, and while the girl spoke and understood English well, she was clearly very constricted at the center. Further discussion with staff indicated that the mother was also very shy when she came to the center.

The team encouraged the center staff to help soften the culture shock for both mother and child. As a result the center staff invited the mother to go on a field trip, suggested that she bring in some national dishes she had cooked, and in general made a point of inviting her into the center and encouraging her to spend more time there. While the team had originally recommended that the child receive the DIAL again, after these steps the child's progress was such that there was no need for reassessment.

The fifth case describes the long-term follow-through the team undertook for a child from a multiproblem family eligible for medicaid. It emphasizes the importance of both the interdisciplinary approach to health care and the role of the day care director in ensuring protracted follow-up.

At entry into day care at age three, the child and her mother, who was under twenty, were receiving counseling at a mental health clinic; the counselor had recommended full-time day care for the child. Initial reports on the child by center staff described her as hyperactive and a behavior problem, and caregivers were particularly interested in having her receive the medical screening and developmental assessment.

The child was screened at the EPSDT clinic in early December. She did not pass the hearing or vision screen so follow-up appointments were made with the EPSDT-sponsored otology clinic and with a private opthamologist. The Denver, which allows for parental report, was within the usual age-range. On the DIAL assessment the child scored below the cutoff point in fine motor development and concepts. The examiners at the assessment questioned her hearing.

Then followed a long series of efforts by the director of the center and members of the team to get help for the child. The director reported screening results to the family worker at the mental health clinic, and told her about the needed follow-up appointments. She also asked the family worker to observe the child more closely. In January the child's otology appointment was not kept because of a snowstorm. At the February appointment the child was rescreened and passed the vision screen but failed the audiogram. The child was to return in March for an ear examination, but this appointment was not kept because the mother was hospitalized. At the April appointment the mother said she was told the child had wax in both ears.

In May, the director and the project nurse discovered the child had not received medical treatment because the parents had not thought wax in the ears sounded serious. The project nurse discussed the problem with the family, and in June, the child was taken to the family doctor. She was given a prescription for ear drops which was left unfilled for some weeks. When it was filled the day care director put the ear drops in at the center as the mother found this difficult to do. The child was returned to the doctor, her ears were flushed out, and the mother was told the ear drums looked "terrible"; the child was again referred to the ear, nose, and throat clinic.

In July, the child went to ENT and was found to have chronic serous otitis media: bilateral impaired hearing. Tubes were recommended as soon as possible. In August the mother said her husband refused to allow the child to have surgery.

In September, the DIAL was done again. The child was above the cutoff point in fine motor but below in concepts, and this time in gross motor skills as well. At the feedback session, the team suggested that the director consider further action, since despite encouragement from the center, the project team, and the family worker at the mental health clinic, the child had not received treatment.

At about this time, the husband left home and the mother and daughter moved in with the child's grandmother. The project nurse then called the mother and assisted the center director in explaining the surgical procedure to her. The nurse also offered to stay with the mother during the surgery. In late November the child was seen again at the ENT clinic and was scheduled for surgery in January, 1979. Surgery proceeded smoothly and on schedule.

After surgery the staff at the day care center noted dramatic improvement in the child's hearing. The DIAL was readministered in April after the child had some months of improved hearing; she scored above the cutoff point in all four areas of the assessment. She was noted to be cooperative during screening, and easily directed. Her teachers also noted greatly improved behavior: she was more socially well-adapted and much less aggressive.

Securing Referral Services

The project found that, in general, the identification of problems was not its most difficult task. Information synthesized from the Health and Developmental History Intake Form, the health and developmental assessments, and caregiver observation proved sufficient for decisions on referrals. The project had far more difficulty in getting the referral sources and services to the children and families who were thought to need them.

Families often had trouble following through on referrals. For some families, services were expensive. For others, services were needed from many different agencies which did not coordinate their aid. For still others, daily pressures made any extra efforts difficult, and the family needed support in order to make those efforts. The interdisciplinary team and the day care staff worked together to try to overcome these problems.

Other problems were endemic to the agencies themselves. For example, for children with apparent developmental delay, the first source for referral was usually the public school. But school districts had different interpretations of the state's special education guidelines, different referral policies, lacked definitive direction from the state Department of Education, lacked appropriate programs, and had frequent internal miscommunications. In other agencies the project had difficulty keeping abreast of the progress of referrals, developing communication systems between the agency and day care centers, and involving the centers in agency decisions about the children referred, again because of problems within the agency. These roadblocks persisted despite meetings and other project efforts to overcome them.

Finding the proper agency to handle a needed referral posed yet another problem. While the university medical complex and a network of services set up by the EPSDT screening clinic could handle most medical problems, there were no like resources for non-medical referrals. Educational resources were particularly difficult to secure, and in some cases seemed not to exist. This was especially true of service for the young child with a degree of developmental delay which did not fit within the current categories of handicapping conditions. Few resources exist for these children; their problems are not severe enough to fit into any category in special education, despite the fact that these children have the greatest potential for remediation and run the great risk of meeting failure if thrown into the system unprepared.

In great part because this large proportion of children can "fall between the cracks" of our service system, the project developed innovative ways to help them while they were in day care. The consultation and training activities described in the next chapter provided a means by which day care staff and parents could help these marginal children and prevent future difficulty for them.

CHAPTER 6: CONSULTATION AND TRAINING

Overview

The technical assistance phase of the project included both follow-through and prevention activities. Follow-through activities ensured long-term case monitoring for children with special needs as identified by the formal health, developmental, or dental assessments, or by more informal observations by parents, caregivers, or project staff. Case monitoring was done primarily through ongoing consultation on children who had referrable and nonreferrable medical or developmental problems. Prevention activities included increasing caregiver knowledge and skills in observation; programming, including record-keeping; working with parents, which may prevent problems for all children in a family; and training for caregivers in child development. This last was particularly important because the more caregivers knew about development, the better able they were to plan appropriate activities and to observe special needs or problem remediation in a child's development.

Consultation and training were the two interrelated means used by the project to achieve follow-through and prevention. We have found that to be effective in enhancing caregiver skills, consultation and training must be closely linked--they must build upon one another. While for clarity of description they are separated here into consultation and workshops (i.e., training), it is important to keep in mind that in practice they were contextually interfaced and delivered concurrently.

The approaches developed by the project for prevention and follow-through will be described in this chapter, as will be some useful instruments developed as we refined technical assistance to meet centers' needs, had mutual goal-setting sessions, and offered various consultation and workshop activities. The tables in Appendix D provide a thorough review of the technical assistance offered by the project to increase caregiver skills in prevention and follow-through on behalf of the young children in their care.

Establishing Relationships with Centers

The foundation for consultation and training was the relationship between the project and the center staff. This foundation was laid during the comprehensive health assessment phase of activities in early fall. Far more than the content of workshops or the knowledge of consultants, this relationship was the critical factor in determining a center's willingness to utilize the information and approaches the project offered.

Obstacles to Relationship-Building

The project encountered some obstacles to establishing a positive, collaborative working relationship with centers. The first of these grew from the start we made with the centers. Launching the project was a complicated operation and funding was late. The project's initial role with centers was ambiguous. This role had to be clarified before a good working relationship with the centers could be establisned. A major issue to be resolved in building the relationship was that of control. The project needed centers to exist and centers wanted the project's services. But in this mutual need, who would make final decisions about service? For example, could the center refuse services the project thought were needed and still continue to receive the services they wanted?

The distrust signalled by this question grew, in part, from the project's affiliations and goals. The project was federally funded--and the federal government is "out to control." We were associated with the university which does research--and "uses kids as guinea pigs." We wanted to "screen" kids--and that's labeling them. This distrust grew out of our assumption in the first year that training and consultation was needed by everyone. While this might be true, the area of need for change had not been identified and agreed upon in advance by the centers and the project. We benefitted from this experience in the second and third years, when we concentrated on clear contracts.

In general, during the first year the project dealt with directors who were supportive, and staff who were often suspicious, indifferent, and in some cases hostile. Our job in dealing with these caregivers was to build a relationship that would turn caregivers' attitudes into those which would be productive for learning. To do this, we turned to contracts.

In the first year we had an informal contract with centers which did not deal with the issues of how frequently and under exactly what circumstances the project staff would be at the center. In the second year these issues were clarified and it was agreed that project staff would be in the center a minimum of two times per month. Finally, in the third year, a similar contract, backed by two years of services and relationship-building, began to produce the trust and reciprocally-open relationship we desired.

Methods of Building Relationships

Certain of our approaches fostered good relationships between centers and the project. Certainly our own internal team building, establishing trust and consensus among ourselves, was an important step toward establishing a good relationship with the centers. The use of formal agreements also helped. But most of our relationship-building was accomplished by the project team member who functioned as coordinator or liaison to each center. This person attempted to establish herself almost as a part of the center, for once trusted in this way she could establish the credibility of the rest of the team. To gain trust, the coordinator visited the center frequently, and during her visits worked with the center's children. In this way she could provide a model for desired behavior and could lessen the distance to herself as "the professional."

The project's attitude toward the center was also critical in forming a good relationship, and was based on several carefully-considered precepts. We held a non-judgemental attitude of respect, particularly toward the center's autonomy, style, knowledge base, and philosophy. Project staff also tried to be sensitive to the concerns of the center--not rushing their development, but responding to needs when the center staff themselves recognized those needs and were ready to work on them. Ideally, we tried to maintain the authoritativeness and perspective of an outsider combined with an insider's understanding of the individual setting.

Final aids to relationship-building were the on-site visits of the entire project team. The team came to the centers to administer the DIAL and to give feedback on it. This provided a good opportunity for project and center staff to become acquainted, as did workshops given on-site during the second and third years. All staff attended these workshops, and eventually the project was able to achieve the reciprocal, open, working relationships necessary for concentrated training and consultation activities.

Needs Assessment and the Caregiver Questionnaire

By the third year, the project had developed a comfortable and productive way to assess a center's training needs. The team did not want just to observe and pass judgement on a center, but rather wanted to find a systematic way for centers to have input into needs assessment. Consequently the Caregiver Questionnaire (Appendix A2) was developed. The questionnaire had two advantages: it provided a systematic means for center staff to assess their own needs, and, in the process, served as a self-educating tool.

The questionnaire covered ten different content areas that project staff considered integral to programming for young children: health, safety, nutrition, gross motor, fine motor, concepts, communication, social-emotional, parent involvement, and staff interaction. These key areas were broken into specific skill dimensions of knowledge, observation, program planning, interaction, utilizing community resources, and record-keeping. These specific skills, in turn, were assessed according to current skill level, importance to the center, and project effectiveness in dealing with training for the skill. The questionnaire also asked in which skills help was desired. While this questionnaire was lengthy, its value in self-education and information-gathering more than outweighed any disadvantages created by its length.

The questionnaire was completed by each caregiver, and a slightly modified version of the same questionnaire was filled out by the center's director and by the project team. When all questionnaires for each center were compiled they provided a profile of assessed needs for that center. Compiled data from use of the Caregiver Questionnaire, and its implications for goal-setting, can be reviewed in Appendices D1-5.

Mutual Goal-setting

Purpose

Once the screening phase of activities was completed and the Caregiver Questionnaire filled out, we needed a way to transform this information into goals for effective and individualized consultation and training for each day care setting. By the third year, mutual goal-setting sessions were scheduled in an attempt to meet these needs. Unfortunately it was only in the third year that the kind of reciprocity that made goal-setting with centers both feasible and meaningful was achieved.

Mutual goal-setting sessions used information from the DIAL group profiles (Appendix A12), relevant health screening results, the center's needs assessment profile from the questionnaires, team and center staff observations, and center priorities. This information, along with the center staff's current ideas, was synthesized and from it goals and priorities for the next six months of consultation and training activities were determined.

The great variation in the goals set by the different centers speaks to the flexibility and responsiveness the team maintained during goal-setting and follow-up. The resultant individualized approach is best illustrated by describing three mutual goal-setting sessions that the team and centers experienced.

Illustrations

In one center, the needs assessment profile was translated almost directly into goals. Center staff requested a primary focus on the social-emotional area, which had not been a focus of project training during the previous year. They also requested information on other topics, such as childhood illnesses and creative movement, to supplement earlier project training sessions. In discussing delivery approaches, the more formal workshop approach, which had been used on-site the previous year, was determined to be most appropriate. Staff and team agreed to have two on-site workshops a month. Consultation was to be provided for individual rooms, and where caregivers' individual goals differed from those of the majority of the staff, the caregiver would attend centrally-offered project workshops.

Another center's requests during mutual goal-setting were much more specific than indicated by the needs assessment profile. For example, the staff wanted information on programming for the autistic-like child. This request the team proposed to meet by bringing in community resource persons. The staff was also interested in developing procedures for their home visit program. The team decided to meet this need by participating in staff meetings on the topic and by assisting the staff to develop guidelines for the visits.

In the third center we provided feedback on the needs assessment profile and asked the staff members if they were still interested in the priorities they had specified. This staff answered no. Their current top priority was staff relations; they were also interested in children's social-emotional development and in parent involvement. After further discussion with the staff, team members concluded that there was a common thread in all these areas—the need for improved communication skills. Although skill development in communications had not originally been planned as part of the project, work in this area seemed to be the best way of responding to the center's needs. So the team provided center staff with one-to-one consultation, group consultation, formal workshops, and techniques for using outside resources, all in the area of communication.

These three examples show the value of a reciprocal working relationship between centers and their respective teams, the need to integrate information gathered about a center, the necessity of individualizing technical assistance, and the importance of providing a variety of consultation and training resources. The tables in Appendices D5-6 provide insight into the range of technical assistance developed in response to individualized center goal-setting.

Consultation

Consultant Roles

The project found that for greatest impact, the consultant had to vary her role to meet the demands of the situation encountered. The continuum of consultant roles, from most to least directive, are described by Gordon and Ronald Lippet in, The Consulting Process in Action. The following is a description of each of these roles, from least to most directive, with examples of their use drawn from the project's third year.

Objective Observer/Reflector: Raises questions for reflection. This is the most non-directive role of a consultant. The project staff made frequent use of this role to stimulate center growth toward independence in programming. This was the major role of project staff when they attended regular center staff meetings.

Process Counselor: Observes problem-solving process and raises questions which facilitate this process. The project demonstrated a systematic process for assessing children's problem behavior and supported center efforts to use this process.

Fact Finder: Gathers data and functions as a researcher. When the father of a child died, the project team collected books and articles to aid the child's caregivers in dealing with the situation. In order to help centers gather information about agencies for possible referrals, a group of agencies were invited to a "Family Resource Panel Workshop," where each agency described its services.

Joint Problem Solver: Offers alternatives and participates in decisions. This role was the one most frequently employed by project staff. In wide-ranging areas of program planning we helped centers define, analyze, and decide upon solutions. We also helped staffs problem-solve in the area of parent involvement.

Trainer/Educator: Trains consumers. During the workshops provided by the project, project staff functioned as consultants working in the training role.

Information Specialists: Acts as an expert in providing information or resources. The project staff exercised this role when they informed a center of the need to report a staff member's TB tine test to the public health department.

Advocate: Proposes guidelines, persuades, or directs during the problem-solving process. Although safety was not a priority for most centers, the project took initiative in creating safety check lists (found in replication training materials) for all centers and strongly advocated their use.[1]

Uses for Consultation

The project offered consultation to serve six major functions. A great deal of consultation occurred as follow-up to the developmental assessment. Teams met with center staff, parents, and personnel from other agencies to discuss results and to recommend action. In one of these cases a child was below the cutoff score in the fine motor area only. While this was not a referrable case by DIAL criteria, center staff requested help for the child. Project staff drew together remedial activities from the parent activity booklet, Big Hands, Little Hands Together (replication materials), and adapted them for use in the area of fine motor development. These activities were then shared with center staff and the parent at a conference.

Health consultation included follow-up of the "Common Illnesses" workshops and of health screening. This was most often referral to an eye doctor or an orthopedist, but other consultation was done. For example, a project nurse helped a child with spina bifida who attended one center. The nurse, a member of the center's staff, and the parent attended the child's medical appointment at the rehabilitation clinic. The team nurse then helped the parent initiate a bowel management program for the child. She oversaw collection of information at the center (i.e., the child's nutritional intake and the number and time of accidents), and made home visits on a weekly basis to help implement the program.

Consultation in social-emotional areas was woven into almost all discussions concerning children. The team dealt with the usual concerns about aggression, separation, withdrawal, and toileting. In two centers there were unexpected deaths--one involving a child, the other a child's parent. Project staff provided information and support to help center staff deal with children's reactions to these deaths and support the families as needed.

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[1] A recent federal audit of Michigan centers uncovered many safety violations.

Many project consultations occurred around curriculum and program planning with both directors and staff members. In one center, the director requested that an educator do orientation and training for a new and inexperienced caregiver. This program came to include three other caregivers, and regular meetings were held with them at the center.

Parent involvement was yet another area for consultation. Centers seemed to have no one definition of parent involvement, and consultation involved anything from informing centers about a special parent-interview video tape being done by the Child Care Coordinating and Referral Service, to providing suggestions and materials for a Make-It-and-Take-It workshop organized for parents by the center. With every opportunity, project staff tried to promote a closer relationship between center staff and parents.

Another important area of consultation was in staff relations. One center requested special assistance with staff communication skills, and the topic was the focus of several workshops held for center directors.

Workshops

A summary of the project's three years of workshop activity shows an evolution in workshop content and methods. In the first year, because of our late start, only a few workshops could be offered. The four basic areas of the DIAL, gross motor, fine motor, concepts, and communication, were covered in a series of workshops offered centrally to all centers.

Second-Year Workshops

In the second year, project staff again used the areas of the DIAL as a general framework for developing workshop topics, but within each of the four areas centers chose topics of most interest to them. These workshops were then given on-site during nap time, with the project providing money so substitutes could stay with the children and all of the center staff could participate.

In this second year each center chose ten workshops, eight in curricular areas and two selected from such topics as: "Dealing with Children's Feelings," "Children's

Sexuality," and "Cultural Differences." A few centers requested more specialized workshops, for example one on spinal bifida which was developed by the project nurse practitioners. When centers requested workshops on topics outside the areas of staff expertise, workshop leaders from other institutions in the community were recruited.

While most of the second-year workshops dealt with curriculum, each workshop had objectives which reflected the project's interdisciplinary approach and each emphasized program planning for the development of the whole child. The objectives for the workshop on gross motor development illustrate this point. One objective was to relate the opportunity for movement activities to the development of self-concept, language, etc. (Appendix A14) while another was to convey information about orthopedic conditions that caregivers could watch for during gross motor activities.

During the second year the project instituted post-workshop evaluation questionnaires (Appendix A15). Caregivers filled out evaluations at the end of each workshop, which gave the project immediate feedback on the content and approaches used. Staff members sometimes also used these evaluations to indicate areas in which they desired follow-up.

Year-end feedback sessions also dealt with training. In these sessions caregivers said the workshops gave them opportunities to focus on topics they normally would not take time for because of other responsibilities. Many said they gained appreciation for topics they had not originally perceived as being useful. Caregivers were also enthusiastic about the handouts and resource materials provided during training sessions.

An overall message to us at the feedback sessions, and one that enabled us to move toward our goal of increased mutuality, was caregivers' acceptance and appreciation of, and respect for, our contributions. They did not feel the project had come to the center as "experts" but rather as people who had the time to pull together information to share and the ability to structure a framework for learning. Because the project learned staff members' needs first-hand, and because they worked with staff in ways that could be applied, the project workshops proved effective.

Third-Year Workshops

Before the end of the second year the project staff had begun to focus on final-year activities. We wanted to become more flexible and responsive to individual center's training requests, as we felt this would encourage more center initiation in training, more mutuality in defining and achieving goals, and more informal consultation. We shared these thoughts with centers, who were receptive but asked that we continue the formal workshops as well. We were able to accomplish both these goals.

For the one center new to the project in the third year, for staff new to the project centers, and for other interested centers who contacted us through the local Child Care Coordinating and Referral Service, CCCRS, we provided most of our second-year core workshops on-site at the new center. These "central" workshops had some important benefits:

1) They provided an opportunity for people from different centers to meet and share ideas, the first step toward the establishment of an inter-center support system.

2) They served to maintain continuity in each center's inservice training despite high staff turnover.

3) Many of the same new staff members and "old-timers" attended each session, and the familiarity of these caregivers with each other contributed to a greater level of participation in activities and discussion as training continued during the year.

4) Repetition of the central workshops allowed us to review the workshop content and refine and/or redesign approaches for delivery.

For the other centers, the mutual goal-setting sessions provided us with insight into what approaches caregivers preferred and what goals they thought could best be met through workshops. The sessions also generated new topics to be explored which called for more variation in methods of delivery and an expanded use of consultants.

In general centers asked us to move from a framework which concentrated on major curriculum areas to one that emphasized social-emotional and health and safety issues. The topics of workshops given during the third year (Appendix D6), demonstrate our response to these center concerns. In addition to workshops, the project met these concerns by developing and implementing a safety check list and health policy prototype and by assisting centers to adapt these forms to meet their needs.

The combination of these individualized, on-site sessions with the central, core workshops was highly effective in both training new staff in fundamentals and in meeting the specific needs of each center. In total, the project provided fifty-three workshops on twenty-eight different topics during the third year.

Interdisciplinary Planning

The project's interdisciplinary approach to workshops produced training materials and methods for delivery which were superior to anything any one of the disciplines might develop alone. Because of team members' different backgrounds, training, perspectives, interests, and strengths, each workshop topic could be more thoroughly developed and could synthesize a much richer array of material. Interdisciplinary planning also ensured that each workshop topic would relate to all of the relevant areas of the child's development--to the whole child.

Factors Considered in Designing Workshops

In addition to the obvious factors such as the participants' interests and needs, and the logistics of time, available space, and group size, the project considered several other factors in designing workshops. One factor was relevance. In the design of the workshops we attempted to combine theoretical and practical information in a way that would be most relevant to the daily needs of the centers. We were successful in this effort because we knew our centers well; we could tailor our workshops to meet the specific needs of each center. In some cases, more theory was included; in others, sections of the content were omitted. We altered the workshops as needed to make them as useful as possible for the caregivers who attended them.

Another factor we considered when we designed each workshop was continuity between workshops. In designing and delivering workshops we did not want to address each topic as a separate entity. Rather, we wanted to show the relationships between different curricular areas, and between cognitive, physical, social, and emotional growth. Our approach in providing continuity included a rationale for each workshop which emphasized the many types of learning and development that could be fostered through curriculum planning. For example, in the perceptual-motor workshop we provided a rationale relating the perceptual-motor skills to the gross motor skills dealt with in the previous workshop. In the woodworking workshop we asked the caregivers to generate the rationale themselves. After participating in several woodworking activities, caregivers shared their ideas of how woodworking contributes to children's development in social-emotional, gross motor, perceptual-motor, math, language, and other areas. This approach enabled us to relate woodworking to almost all of our other workshops.

A third factor we considered was how to provide for maximum participation. We wanted each of our workshops to be as experiential as possible, since we knew that the more actively involved the participants were, the more they would gain from the workshop. We also wanted to model alternatives to formal presentations with questions and answers, since we were encouraging caregivers to teach their children through concrete experiences. We had greatest success with this goal in the third project year. This was largely because the content of the core workshops was by then established, so we had more time to devote to delivery methods. Also, by the third year we had a more solid relationship with each of our centers, so we were able to risk counting on their participation as an integral part of the workshops.

Methods of Delivery for Workshops

Formal presentation and time for questions were usually combined with participatory and experiential methods like the following:

During some workshops caregivers participated in activities for children. For example, a large portion of the woodworking workshop was set aside to explore the variety of woodworking materials we had collected. For some caregivers this was important to their gaining enough confidence and knowledge to begin doing woodworking with children. In the rhythm workshop, the caregivers participated in a variety of music and movement activities, with the presenter leading the activities and modeling how they might be done with children. This was also true in the cooking workshop and in the workshop on curricular activities that promote social-emotional growth.

Another technique used to promote participation was problem-solving. For example, in the perceptual-motor workshop the presenters first defined a variety of perceptual-motor skills. They then asked small groups of caregivers to come up with as many ways as they could to use a selected learning material to promote those perceptual-motor skills. It was fun, and it gave participants a chance to apply what they had just learned. We used a problem-solving session to open the social-emotional workshop, "Dealing with Problematic Behavior." The caregivers volunteered their ideas on what things they would try to find out about a child if his or her behavior caused them concern. Caregivers came up with a long list of suggestions via this problem-solving approach, which illustrated to them how much they could do without external consultation.

A third delivery approach we used was role playing. We didn't use this method often, but at times the most appropriate way to sensitize caregivers to how children or parents feel was by having them play the roles of children or parents in a situation. Role-playing was possible only after we had built a good relationship with a center over time. It was then very effective.

Other techniques we used, which need no explanation, were displays, films, "make-it-and-take-it," and handouts.

Follow-up and Evaluation for Consultation and Training

Follow-up

A lot of information is delivered in a short time at a workshop. To enhance the effect and relevance of the material presented, it is important to reinforce it after the workshop is over. In this follow-up, as in so many other aspects of the workshops, the coordinators played a signal role.

One successful method of follow-up was to distribute handouts which extended a given workshop. For example, within the handouts for the rhythm workshop was a list of community music resources. One handout for the gross motor workshop was a set of instructions for making gross motor equipment in the center after the workshop. One handout for the perceptual-motor workshop was a list of activities beyond those dealt with in the workshop.

Another follow-up method was to carry through, as much as we could, with the requests for follow-up expressed by caregivers on their workshop evaluation forms. Sometimes this meant delivering resource materials to them or lending them equipment. Sometimes follow-up was more elaborate, such as compiling a develomental checklist of gross motor skills, as we did with two centers after the gross motor workshop.

A third kind of follow-up occurred during our visits to the centers. Whenever we observed any changes that had been made in response to a workshop we reinforced the change with encouragement. We also occasionally modeled activities with children that had been shown at a workshop.

The last kind of follow-up we did was consultation which arose from requests at the workshops. Often caregivers asked for help with individual children during a workshop. We followed-up on these requests by having that center's team observe the child, meet with the staff, or provide other appropriate consultation.

We would have liked to do even more follow-up. If we had a fourth year we would work on other ways to follow up workshops with consultation. We would also follow up by having more frequent mutual goal-setting sessions so that centers could clarify or amend their goals as the year progressed. Project staff had hoped to try this with centers, but because six rather than eight months were available for training, only a few centers had a second opportunity to set goals, and this occurred late in the third year.

Follow-up with Directors

In the beginning of the third year, the project held a meeting with center directors to formalize their participation in the continuation of the project and to orient them to changes in third-year activities. At this meeting the directors requested regularly-scheduled directors' meetings to explore ways to reinforce and follow-through on screening, consultation, and training activities with their staffs.

These meetings proved to be singularly valuable for increasing directors' effectiveness in supporting skill development by their staffs. The topics for these meetings revolved around communication skills and management issues. Several project staff members were routinely involved in these meetings, with other staff members and the center directors acting as additional resource persons. The meetings provided support for the directors and reinforced the training and consultation occurring in their centers. The sessions also increased the directors' use of consultation resources from the project and from the community to help directors meet their roles and responsibilities.

Evaluation

The project had three methods for evaluating our workshops and consultations. First were the evaluation forms that caregivers filled out after each workshop. These were designed to assess the extent to which we met our specific workshop objectives. The aggregate results of these forms and the degree to which we met the workshop objectives were collated by the evaluators and are included in Appendices D8-30.

Second was our own self-evaluation. After each workshop we first read the caregivers' comments on the evaluation forms, and then had our evaluation session. The object of these sessions was to give supportive feedback to those who had developed and presented the workshop, and to see what all of us could learn from it that we could apply to future workshops. We did this by generating all the positive comments we could think of about the workshop's content, objectives, methods of delivery, etc., and all the suggestions we could think of to make the same workshop better in the future, or to improve any other future workshop.

The third aspect of evaluation was our assessment of the overall goal-attainment of each center. This was an attempt to assess the extent to which goals set at mutual goal-setting sessions were attained as a result of the project's consultation and training activities. We also used these sessions to assess the value of our longer-term assumptions about the interrelationships of health assessment, consultation, and training; the value of the interdisciplinary approach; and the impact of increased caregiver skills on prevention.

CHAPTER 7: FAMILY DAY CARE

Background

The process of developing a program for assessment and follow-through for children in family day care (FDC) was very different from the process used to develop that program for the centers. In part, this was because the center program was a very ambitious one, and drew virtually all the time and staff available to the project during its three year tenure. Creating a completely different program for FDC was beyond our resources, yet family day care homes had different needs than centers. It was in the third project year that we were able to get some resolution to this difficulty.

In the first two years of the project, family day care assignments were added on to center assignments, with many staff members having one or more homes to work with. In the last year, the staff member who had most interest in and rapport with family day caregivers was assigned to work with all FDC homes (in addition to working with one center). With the help of one evaluation specialist, this coordinator was then able to work out a more consistent approach to working with family day care, including assessing FDC needs, establishing informal goals, and providing services. By the end of the third year, a link had also begun to be established between some family day care homes and one center.

As with day care centers, the extent to which project goals could be met with FDC depended on the relationship, trust, and rapport between the FDC consultant and the FDC-giver. But the nature of the FDC setting altered the ease with which this relationship could be forged. The FDC center is smaller, home-based, and more isolated from the flux of happenings than the larger center. This is the great advantage of these homes, and FDC-givers are protective of the privacy and degree to which outside influences affect their environment. While these conditions offer many benefits for children, they did make it more difficult for us to establish the communication and trust necessary to help these homes make optimal use of community health and program resources.

Securing the Homes

In the first year of the project we established a procedure for recruiting and orienting FDC homes which we followed, with minor variations, each succeeding year. We obtained a list of homes registered with the local FDC council and the Department of Social Services and sent a letter with a general statement about the project to each home listed, with a return interest slip. After two weeks, each home was contacted by phone to see if the FDC-giver would be interested in more information about the project. If an interest slip were returned or if interest were expressed during the contact phone call, we made home visits to give caregivers information about the health and developmental assessments and about project resources. Five homes agreed to be in the project the first year, and a meeting for participating caregivers and project staff was held. Three of the five caregivers attended this meeting.

Two of the five first-year homes continued to participate the second year; the three who dropped out did so because they were no longer functioning as FDC homes. In the second year we followed the same procedures for securing the homes, except that our initial letters included an extra letter describing the project in some detail. In this year two FDC-givers attended the meeting with project staff, but a total of ten homes joined the project. For each of these ten homes an agreement was written which detailed the responsibilities of the project and the FDC-giver for the year.

In the third year the second-year procedures were again followed for recruitment, orientation, and reaching agreements, but no general meeting was held. Eight homes participated in the project during this year: three were new homes, three homes continued from the previous year, and two homes had been with the project since the first year. Other providers from the second year had withdrawn because they were no longer caring for children or were no longer interested in the project.

Initially, the homes secured for the project were to be those with low-income children whose day care was supported by the state Department of Social Services (DSS) or those led by FDC-givers who were willing to accept DSS children. This goal proved to be unfeasible. First, in using the DSS list to contact homes, we found the list was both incomplete and dated, making it difficult to locate the kinds of homes we had targeted. Then, when some homes with DSS-supported children were located, some of the caregivers were unwilling to identify or tell us the number of DSS children in the home, feeling it was inappropriate to divulge this information about the parents. Finally, we found many FDC-givers unwilling to accept DSS children at all. Their reasons were non-payment and slow payment from DSS, payment which was too low, and difficulty in interacting with DSS parents. Since most FDC-givers were suspicious of the project and unwilling to join anyway, we finally decided to accept those FDC homes which could be persuaded to accept us, whether or not the home accepted DSS children.

Health and Developmental Assessments

Our first major involvement with FDC was for health and developmental assessment. To get permission for children to be assessed, letters were given to FDC-givers for each child's parents. This was the same letter given to the parents of children attending day care centers participating in the project. It included a description of the project and a permission slip for the health and developmental assessment (see Appendices A7 and 9).

All FDC children were given permission to have the health assessment the first year. This was probably because the FDC-givers, who were trusted by the parents, could stand in for the parent who then need not take time from a job or school. The second year and third year responses to health screening were much lower, probably because parents were required to attend the screenings.

The parents' response to developmental assessment was less enthusiastic. In the first year, five developmental assessments (DIAL and DDST) were given to family day care children in two day care centers. A total of nine other developmental screenings were given in three of the family day care homes. No permission slips for the developmental assessment were returned in the second year. In the third year two were returned and both assessments were given at a day care center. The numbers of those receiving the developmental screening are small, in part because only a DDST type of assessment is useful for the FDC setting.

Goal-setting, Consultation, and Training

The First and Second Years

In the first and second years, goal-setting was an informal process. Goals were the caregivers' expressed interests or needs. Consultation and training activities in the first year were equally informal, and were generally aimed at developing basic skills. Training the first year (or in the first phase for new participants in following years) was largely "consciousness raising" about children who might need special observation. Consultation which took place in the family day care homes was somewhat more formalized. The topics and skills discussed, assessed, or demonstrated varied from home to home but generally consultation followed a sequence of skill development to meet the informal goals of the caregiver.

In the second year, family day caregivers were included in the more structured programs offered to the centers. Caregivers were given a list of scheduled central and center-based workshops and were encouraged to attend them. The project paid for substitute caregivers during any workshops the family day caregiver chose to attend and caregivers were offered transportation to and from the workshops. However most caregivers had difficulty arranging for a suitable substitute or preferred not to leave their children with outsiders, so only two attended workshops. All providers received consultation in home visits during the second project year.

The Third Year

Because in the third year one project staff person (backed by an interdisciplinary team) was responsible for FDC programs, our work with caregivers had greater continuity, and our service delivery was more systematic and directed than in earlier years. For example, in this year the Caregiver Questionnaire that was given to center caregivers was given to FDC-givers to assess their needs and interests (Appendix A2). An Observation Checklist was developed by the FDC coordinator (Appendix A16) to help caregivers observe their children's development. Home visits occurred more often, and sequential activities which led to caregiver goals were developed for these visits. Logs (Appendix A17) and individual summary records were kept by the coordinator for each home. And finally, regularly scheduled FDC team meetings were held to help the coordinator plan for each home.

By the third year a more effective approach to establishing caregivers' goals had also been developed. Unlike the arrangements for day care centers, there was not a goal-setting session with the family day caregiver and the project. Instead, the family day care coordinator informally discussed with each family day caregiver her or his preferences for training. This information was combined with information from the Caregiver Questionaire, the checklist, and individual FDC files of the caregiver's expressed concerns. From this information, caregivers could select up to three training goal areas, and goals were made in accordance with learning in these areas. In this third year five caregivers had two goal areas, and two had three. The goal areas were limited because of the limited training time and training personnel available and because the FDC-givers concern for training was generally lower than that of caregivers in the centers.

With two or three possible goal areas selected for each family day caregiver, the family day coordinator identified the approaches which would be used in working toward the goals:

1) Workshops: either centrally-located and available to all caregivers from homes and centers, or scheduled for one center in which the family day caregiver could participate;

2) Information collection and delivery: references, lists of resources, handouts from workshops the caregivers could not attend, and the project's toy and book lending library items.

3) Consultation: scheduled periodically as needed, or on a regular basis, to cover areas of major interest to the family day caregiver and to include the above resources.

With goal areas selected and project approaches for working toward the goal areas outlined, the family day care coordinator met with each family day caregiver in the home and presented the individualized training plan she proposed. The plan was not presented as a *fait accompli*, but rather as a possible coordination of the caregivers' needs with the training approaches used by the project. While the plan represented somewhat less caregiver involvement than that used for centers, this more directive approach did allow the family day care coordinator to offer the best project resources with the personalized contact inherent in the family day care consultation process. The goal areas thus developed and proposed were accepted by all the family day caregivers (Appendix D41).

The family day care coordinator next constructed, for each goal for each family day caregiver, a Scale for Goal Attainment, by which the coordinator and the caregiver could assess progress toward individualized training goals (Appendices D41-42). A further discussion of this scale is included in Part III.

The family day care coordinator also kept summaries of training efforts which would be made to meet the FDC-givers' goals. The summaries included the following information for each goal: the goal area; the approaches for working on the goal (workshops, collection and delivery of information, consultation); the current delivery status of each approach; and the current progress toward each goal. As with the summaries for the day care centers, these goal summaries may be used as a framework for tying together data to evaluate the training process; this is discussed further in Part III.

Illustrations

Because each family day care home is unique and because an individual program was developed for each home, our interactions with FDC homes varied widely. For the most part FDC-givers wanted the consultation services available through the project. The comprehensive health assessment resources were only used when they were very easily accessible, as during the first year's approach, or thereafter if there was very special concern about a particular child. Training opportunities were used even less. Thus a variety of consultation activities and approaches had to be developed to meet home caregivers' goals and needs. The following experiences illustrate some of these approaches.

The first illustration shows the importance of trust and rapport with the home. The caregiver in this home had been reticent about receiving the project in the beginning, thinking the coordinator was another DSS worker. But the coordinator began to make visits, during which the caregiver began to talk about a family matter. The coordinator suggested some contacts which might assist the provider. And when these proved effective the doors were opened for more frequent visits and more communication. Soon the caregiver evidenced a desire and need for the coordinator's regular assistance.

Within six months of the beginning of this interaction, a sensitive issue arose with one of the children in this provider's care. The child witnessed a sexual assault from her sandbox at home. The parents were very concerned about the child's social-emotional health and the caregiver turned to the coordinator for help.

The coordinator was able to recommend several community resources, and talked with the caregiver about helping the parents cope with the incident. The caregiver was then able to help the parents consider the issues, and their values and feelings about sex and the situation. This support, in the end, enabled the parents to talk constructively with the child about the incident. Clearly, the coordinator's rapport with the caregiver was pivotal in resolution of this problem. This kind of relationship most often took a year, and sometimes two years, to develop.

Another situation illustrates the importance of the interdisciplinary back-up for the FDC coordinator. In the first project year, a FDC child went to a health and developmental assessment at a "link" center. Here the mother expressed concern for the child's apparent physical discomfort. Following the assessment the project nurse suggested a resource for further examination where the child was found to have a vaginal infection. The project nurse followed-up with support to the mother who in turn got treatment for the child.

The third illustration shows the possibility of using the FDC home for education--of both the children and the caregiver. The FDC coordinator planned cooking activities for each holiday (like pumpkin carving and cooking for Halloween). During these sessions the coordinator demonstrated how concepts of texture, taste, color, and size could be introduced during cooking activities to increase children's learning. She also demonstrated good nutrition to the caregiver by bringing in and using healthy, non-processed ingredients. The coordinator would then leave ideas for follow-through activities with the caregiver, in this case a children's cookbook, which allowed the caregiver to extend both her own and the children's learning.

Another example of the educational opportunities available at the FDC center involves a kindergarten-aged child who attended a FDC home half-days and who did not know her colors. The coordinator was able to provide activity ideas and support to the FDC-giver for working with the child. She also left toys from the project's toy lending library to aid the caregiver in her efforts.

In addition, the FDC coordinator gave caregivers support for administrative activities like arranging fee payments, taxes, insurance, food expense reimbursements, and scheduling. The first illustration of this involves a caregiver who had problems with a parent paying according to the fee scale the caregiver had set. The parent was leaving the child longer than agreed upon. The coordinator suggested making and posting charts for fees and for parents' time schedules. When this was done the parent started to call and ask the caregiver to "just send the child home." The caregiver felt that someone should accompany the child, and so was uncomfortable with this request. The coordinator suggested the caregiver write a list of rules for participation in the FDC home, making clear what her expectations of parents were. She did this in a letter to parents, and the parent with whom she had had difficulties began to meet her expectations. In addition the caregiver found she had improved communication with other parents.

The second example of the coordinator's administrative assistance is in dealing with taxes, food reimbursements, and insurance. To help caregivers solve problems in these areas, the coordinator referred caregivers to the FDC council service, helping them draw on council resources which were both available and needed. The coordinator followed-up on this referral by helping caregivers do the paper work necessary to receive the council services.

In all, many unique and varied approaches were used with FDC-givers to help them build and support more effective day care resources for children and their families.

CHAPTER 8: SERVICE COORDINATION EFFORTS AND THEIR IMPACT

The project's plan to demonstrate ways to coordinate community resources on behalf of children and their families was based on two assumptions: first, that the increased use of resources would be of mutual benefit to day care providers and to agencies; second, that coordinated provision of services would mean less fragmentation and duplication and more effective delivery of the preventive and remedial resources available. Increased use of services under this system would demonstrate the capability of community resources to support families and of day care to serve as a channel for families to secure agency services.

Coordinating and Providing Services

Our first-year goal of having agencies deliver services directly to the centers helped by project coordination was overly ambitious--agencies simply were not willing to so completely alter their delivery methods. Realizing this, in the second and third years the project turned to a broader, two-pronged approach to service delivery. The project developed innovative methods for service delivery, provided some services itself, and contracted with agencies for other direct services as needed. The project also began a thrust to support coordination of services by agencies in the community. These agencies would, in turn, provide direct services to the centers. Being housed together as an interdisciplinary staff was fundamental to our being able to orchestrate these thrusts. It allowed us to explore and develop innovative interdisciplinary materials and delivery methods and to communicate easily about both internal and agency-linkage activities. We highly recommend this method for local service delivery.

Agency coordination was a large task to accomplish in the time we had available. We began by becoming well informed about, and familiar and experienced with, the human service resources in the community. From this base we worked to develop relationships and communication between line staff at the various agencies.

Eventually three channels were developed to facilitate this process. First was the advisory committee to the project. This committee was widely representative of agency resources in the community and provided visibility for resource providers. Second, during the second project year the local Community Coordinated Child Care (4-C's) affiliate, Child Care Coordinating and Referral Service (CCCRS), began to hold meetings to consider organizing a resources consultation network. These two efforts generated a third opportunity for agency resources to get together:

the intermediate school district representative, who attended both meetings, began to host luncheon discussions where resource people described to one another the services, and the regulations affecting those services, available through their agencies.

Initially in these meetings, providers were pleased just to be able to put "faces on agencies." But as time went one, service providers learned who specific referrals should be sent to at other agencies. And eventually these meetings became the channels through which issues were resolved, cases were mutually dealt with, and the rewards of reciprocity and increased effectiveness were discovered. Overall growth in the reciprocal use of resources between day care and community services can be reviewed in Appendix E.

Meanwhile, other project efforts toward direct services continued. The project initiated meetings between day care directors and personnel from various community agencies. Project teams facilitated the use of agency resources through training, consultation, and follow-up referrals for children and families with special needs. Project staff also assisted CCCRS in developing and disseminating a Washtenaw County resource guide for children and their parents, "The Children's Yellow Pages," (Appendix A18) which further boosted agency use.

This emphasis on the use of agency resources in turn increased the value of the resources network. Day care directors were able to use more resources and to use them in a more selective and consistent manner because agency services were made clear and because less overlap in their services existed. As centers came to value this, they too helped agencies coordinate services. For example, in one center concerned about the development of two siblings, the director called a meeting of those aiding the children. Twelve agencies were represented, some of which knew of other agencies' involvement and others of which did not. These resource people then worked to better coordinate their services to the family.

Major Coordination Efforts

Since CCCRS first began to hold consultant network meetings in the project's second year, strides have been made to coordinate community efforts on behalf of young children and their families. Several major coordination efforts were generated by the early CCCRS consultant meetings. First, a committee of interagency staff members was formed and backed up by the agency directors. The committee included representatives from CCCRS, the project, the Washtenaw County Health Department (WHD), Washtenaw County Community Mental Health (CMH), and the Washtenaw Intermediate School District (WISD). United Way staff expressed interest in the committee but could not attend. This committee met at three-week intervals to examine issues and to develop recommendations about the needs of young children and their families and the service delivery systems which would meet those needs. The report of this committee to their respective agency directors is in Appendix A19. This committee continues to meet to address issues evolving from efforts to reduce fragmentation and increase services to young children and their families, and to increase service linkages to day care.

The second major result of early project advisory committee and CCCRS consultant meetings was the Consultation Referral Service coordinated by CCCRS. This is an interagency network of consultants organized to enhance the quality, availability, and delivery of consultation services to caregivers of children from birth to five years. A copy of the pamphlet which publicizes the consultation referral network is included in Appendix A20.

A third major coordination effort was begun in the third year of the project. A staffing agreement was reached between CMH, CCCRS, and the project, whereby two half-time staff members from the same CMH team worked half-time with CCCRS and the project respectively. This fulfilled an original project goal of involving community agency staff directly with the project as a means of expanding use of the project's methods of service delivery. The CMH person attached to the project became the social work member of one team and served several centers. She found the team experience very salutary and is trying to continue some form of it in post-project CMH service to the day care community. This interest and support from CMH greatly aided the growth of coordinated services in the community and also helped the spread and adaptation of the project's interdisciplinary methods and materials.

The project made a final coordination effort with centers and agencies to promote continued use and adaptation of the project's methods and materials. As part of this coordination effort, in the early fall of the third project year, two persons from each agency (CMH, WPH, ISD, and CCCRS) were trained in the use of the DIAL. These staff are now part of the Consultation Referral Service coordinated by CCCRS. CCCRS will use the project's interdisciplinary training materials to provide training and referral to day care centers and public agencies serving young children and their families and will coordinate adaptation of project methods and materials for community use in the future.

The impact of coordinated adaptation and use of project methods is already being felt in the community. Two centers that participated in the project are now attempting to establish their own interdisciplinary teams. One center has put in a formal request for such a team to the CCCRS interagency committee. The other, now headed by a former project staff member, is coordinating efforts by its public health nurse, social worker from a community agency, and education staff.

Results of Coordination Efforts

The project's coordination efforts affected the commuity in three ways. The project strengthened community coordination of resources for young children and their families; enhanced the reciprocal awareness and use of the community's institutional resources and day care centers; and in the process, developed innovative methods and materials that day care and resource providers could use.

On a state and national level the project's methods and materials are timely and have potential for future use. In Michigan, the Interagency Committee for Services to High Risk Children and their Families is planning to increase interagency screening, some in the day care population. Title XX funds have been appropriated in the Michigan legislature to begin a large training effort of day caregivers, and some of the project's principles, methods, and materials will certainly be used. On a national level, the new Federal Interagency Day Care Regulations mandate training of caregivers, and the project materials on health have already been cited as directly on target for this kind of training. Also in the federal sphere is the future enactment and implementation of the Child Health Assessment Program (CHAP). The project's methods and materials can be a valuable resource for the design and implementation of a child health policy as it relates to the children in day care and the community's agency linkages to the day care facilities.

PART III: THE EVALUATION

Submitted by:
Nancy L. Shiffler
Margaret D. McNiven
Jeanne B. Martin

Consortium for Evaluation Research,
Training and Service

The University of Michigan
School of Education

LeVerne S. Collet, Director

CHAPTER 9: BACKGROUND FOR THE EVALUATION PROCESS

The Role of C.E.R.T.S.

The Consortium for Evaluation Research, Training, and Service became involved with the City-University Project in August 1977, when the project director requested assistance in writing the first year final report after the project's initial evaluator had resigned. During the second project year, C.E.R.T.S. provided technical assistance (data collection and analysis, consultation, etc.) to the new project evaluation specialist and, in June 1978, assumed full responsibility for the evaluation of the third and final year of the project. For this final year evaluation we felt it was desirable to maintain continuity with previous evaluation efforts, but it was also important to correct what we perceived as weaknesses in the earlier evaluation designs and measurement procedures.

In the third year the project too was involved in change--integrating ideas and procedures developed during the first two years into their service delivery model. In the third year the model became operational in a form which reasonably satisfied project staff.

Because of the changes made in the service delivery model, the third year evaluation is actually an evaluation of the implementation phase, as opposed to the developmental phase, of the project. And seen as such, the focus of evaluation must be the project as it operated during the third year, backed up, where appropriate, with information from the first two years. This approach will be taken particularly with regard to the training component of the project, which evolved furthest over the course of the three years. The follow-through component, which included fairly consistent record-keeping over the course of the project, will be evaluated for all three years.

The Evaluation Design and the Format of this Report

There are two parts to the evaluation of the EPSDT-Day Care Project: evaluation of the program per se, and evaluation of the potential for dissemination of the project's interdisciplinary approach. The plan for evaluating this project was based on the Conceptually Structured Program Evaluation model. The essential idea of this model is to specify the chain of events through which the desired outcomes will occur. A basic principle of conceptually structured evaluation is that measurements ought to be taken at each stage of the chain in order to chart the progress of program effects through the chain to the outcome variables. This approach is particularly useful for this project because of its long-term outcome goals. Progress toward those goals may be demonstrated even when not enough time has elapsed for changes in the final goals to be indicated. In addition, this approach to evaluation helps to provide the needed documentation of the project's method for dissemination purposes.

The report which follows is organized according to the conceptual framework diagrammatically described in Figure 1. For each box in the diagram, the data collection and results are discussed. Thus, there are three major sections to the report:

1) Inputs to the process (Chapter 9)--a description of the pre-intervention characteristics of the centers, agencies, and children and of the operational characteristics of the interdisciplinary team;

2) Process (Chapter 10)--the characteristics of and degree of implementation of the project's interdisciplinary, comprehensive approach to intervention;

3) Outcome and Demonstration Goals (Chapter 11)--the impact of the project's approach on the health and developmental status of the children involved in the project, and the adaptability of the project's approach to other settings in this and other communities.

Project Components Characterized

Pre-Intervention Characteristics of the Centers and their Staffs

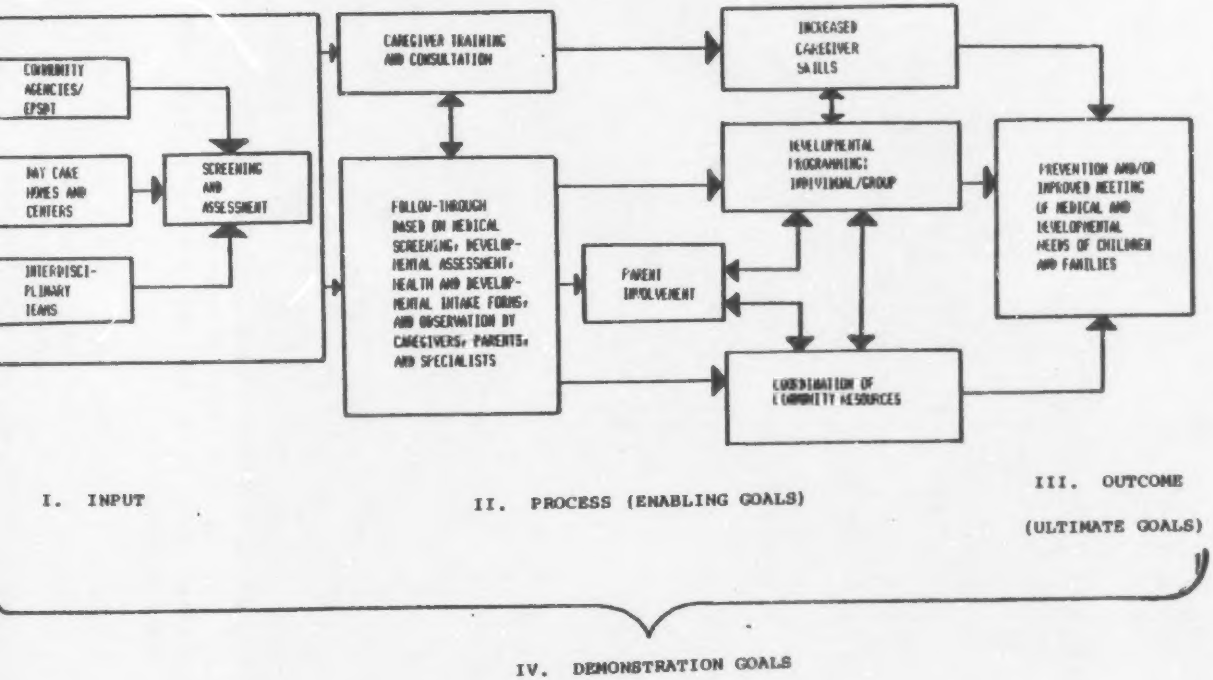
These characteristics have been summarized in Chapter 3 of the project report.

Pre-Intervention Characteristics of Interagency Linkages

In 1976, the local school district Office of Pupil Personnel, which was charged with the responsibility of locating children with handicaps and learning disabilities and beginning remediation of these problems, reported that over a two year period since September 1974, only three day care centers had contacted them.

This was a statement of the nature of the interaction among centers, homes, and community agencies prior to project intervention. While interviews in 1978 with key

FIGURE 1: CONCEPTUAL FRAMEWORK FOR INTERVENTION STRATEGY


COMMUNITY AGENCIES/ EPSDT
DAY CARE HOMES AND CENTERS
INTERDISCI-PLINARY TEAMS
SCREENING AND ASSESSMENT
CAREGIVER TRAINING AND CONSULTATION
FOLLOW-THROUGH BASED ON MEDICAL SCREENING, DEVELOP-MENTAL ASSESSMENT, HEALTH AND DEVELOP-MENTAL INTAKE FORMS, AND OBSERVATION BY CAREGIVERS, PARENTS, AND SPECIALISTS
PARENT INVOLVEMENT
INCREASED CAREGIVER SKILLS
DEVELOPMENTAL PROGRAMMING: INDIVIDUAL/GROUP
COORDINATION OF COMMUNITY RESOURCES
PREVENTION AND/OR IMPROVED MEETING OF MEDICAL AND DEVELOPMENTAL NEEDS OF CHILDREN AND FAMILIES
I. INPUT
II. PROCESS (ENABLING GOALS)
III. OUTCOME (ULTIMATE GOALS)
IV. DEMONSTRATION GOALS

agencies revealed a wealth of services available to the day care population (see Appendix E1), few of these were being utilized, in part because the agencies had limited outreach programs.

In the first project year, center directors were asked to indicate which resources, from a list of twenty-one names provided, they utilized on a regular basis. A comparison of the responses of the four directors who were interviewed before and after intervention by the project during that first year shows that before intervention the directors cumulatively checked a total of twenty-three resources (sixteen different agencies).

The length of the agency list provided to the directors was also a comment about the narrow band of the project's perspective on the availability of resources in the first year of operation: the agencies listed were only the most visible in the community.

Data are not available to describe agency use by the first year family day care homes, as these caregivers were not interviewed that year. However, in the third year, prior to the setting of formal training goals, the family day caregivers indicated their familiarity with resources, which was recorded on the Family Day Care Checklist (see Appendix A17). Prior to the third project year, each family day caregiver had used at most three resources, either for a family day care child and/or family, and/or for themselves or their own family. The resource most frequently reported as used was the public schools. Health care facilities were the next most common resource used; third most often used was the library. Places of worship and counseling services were used by several family day caregivers for themselves and their families. On a four-point scale (4 = a lot of usefulness), ratings of usefulness of all resources ranged between 3 and 4, as reported by the family day caregivers.

Thus, prior to formal training activities, which were not necessarily directed at the use of community resources, the family day caregivers generally utilized a narrow band of resources and were satisfied with the usefulness of the service they received.

Interviews conducted in 1978 with eight key agencies verified that resources were available in the community to attend to the problems addressed by the project. Appendix E1 tabulates the agencies' activities at the time. Help to improve health care practices in day care centers and homes was offered directly by three agencies, one other agency would attend to referred problems in health care practice, and one agency funded any attempts to improve health care practices.

Six of the agencies interviewed had programs to help day care staffs develop appropriate curricula and materials for use in guiding the development of children. Assistance in locating sources of social services for families with children in day care was available to caregivers primarily if they actively sought help from the agencies. Consultation and training in staff development of interaction skills was available from three agencies and one other agency accepted referrals for training. Systematic assessment of children and intervention as needed was only readily available from the health department of the eight agencies interviewed, although other agencies accepted referrals or provided funding for assessment and intervention. Follow-up help for problems was available from several agencies both directly and upon referral.

The availability of services to day care facilities and preschool children in 1978 varied in accessibility and quantity, but did cover the problems the project was addressing on behalf of the day care population. This would make possible a transfer to the local community agencies of responsibility for extension and coordination of services to day care centers and homes.

Pre-Intervention Health and Developmental Status of Children in the Project Centers

The results of the first-year health screen appear in Appendix B4. Because the incidence of any one medical problem (e.g., low hematocrit, high lead count) was very small, these were lumped into a single "other medical" category. Data for these and all other screening results are based on the follow-through records kept by the project.

While nearly half of the children screened the first year had one or more health problems, more than one third of these were already under care. Just under 20% of the children needed referrals. The figures for any given problem type are too small to draw any conclusions, although the referral rates for hearing problems and, collectively, medical problems are high relative to the other areas.

DIAL results for the first year are presented in Appendix B3 along with results for the second and third years. Again the number of problems was relatively low. Six children (5.3%) were down by DIAL criteria, and an additional 8% were down in one area only. None of these problems was referred the first year, partly because the screening took place relatively late in the year and the follow-through essentially ran into the second-year DIAL screening. In addition, project staff were just getting acquainted with center staff and children and were reluctant to refer children until they had more background information.

The numbers and percentages of children receiving each type of screening or assessment over the three years is presented in Appendix B1. A small number of children under two and a half years were given the Denver Developmental Screening Test (in circumstances other than the EPSDT screen) and the Bayley Test. Because the number was small, these cases will not be dealt with separately at any other point in this report. The number of children receiving one, two, or three screens is presented in Appendix B2. In all, 616 children received some form of screening or assessment during the course of the project.

The Interdisciplinary Teams

The basic functioning of the project's interdisciplinary teams is described in earlier chapters of the project's report. The purpose of this section is to provide some descriptive information about their operation, particularly in terms of their direct contacts with centers. Data are drawn from the third year logs of team visits to centers and, more anecdotally, from the minutes of the team meetings.

Team work in the centers was divided roughly into six categories: training, screening, follow-through, planning of project efforts, administration, and social activities. Training included formal and informal workshops, workshop follow-up, and consultation. Screening primarily involved the administration of the DIAL. Follow-through included feedback of screening/assessment results, program planning for individual children, observation of individual children, consultation with staff or parents, and community contacts. Follow-through and training are not, and should not be, completely distinct, since the project saw training as one form of long-term follow-through. For purposes of this categorization, however, a log entry was considered follow-through if it concerned a specific child. Planning of project efforts included orientation meetings for centers, mutual goal-setting sessions, planning workshops with center staff or directors, and general visits and observation. General visits were primarily a way for project staff to be "available" to centers. These visits often resulted in training or follow-through consultation with individual caregivers. Administrative functions primarily involved delivering or picking up materials or forms and setting up meetings and workshop schedules. Social activities included parties and potluck dinners with center parents.

From September to June of the third project year, project team members made, on the average, about 65 visits to their centers (range: 46-82), or about 6-7 per month. Total time spent in these visits for the ten months was approximately 90 hours per center (range: 57-112 hours), or about 9 hours per month on the average. Actual time per visit varied considerably, however, ranging from a few minutes to drop off materials, to all day during DIAL screening.

The mean proportions (means of individual center's proportions) of visits and time spent at centers for each activity are presented in Appendix C1. It is important to keep in mind that these proportions are only for direct contacts with centers; they do not include, for example, time spent at the project office developing workshops. Appendix C2 shows the distribution of each of these activities in bi-monthly intervals across the course of the third year. Number of visits and time spent per activity are given. As can be seen, screening took place primarily in early fall, except for the DIAL pick-ups in January and February. Follow-through peaked slightly in late fall, right after screening, but remained relatively constant all year. Planning activities were fairly constant across the year, although they were somewhat higher in late fall when mutual goal-setting took place. Training activities increased during the second half of the year, during which time most of the workshops were given. Administrative activities ran at a relatively low but constant level across the year. Social activities were too infrequent to include.

About one-third of the visits, 44% by time, were joint visits made by two or more team members. The team coordinators, who handled most of the administrative contacts with the centers, alone accounted for 39% of the visits, 35% by time. Single visits by the other two team members accounted for 30% of the visits, 20% by time.

The three interdisciplinary team members worked together to integrate their areas of individual expertise. Each team member served as a generalist, not in the sense of an individual operating across disciplines, but rather as a specialist who could also take into account the resources and frames of reference of other disciplines. Thus the minutes of team meetings indicated that each member carried out training and follow-through activities including contacts with community agencies, in her own discipline, but the teams worked together to make certain that each discipline was represented in the content of each workshop and in each follow-through decision made.

The physical proximity of the team members, having them all housed in the same office, may have had a considerable effect on the coordination of the disciplines. Informal, everday contacts reinforced the team's more formal meetings and increased communication. It is less likely that this sort of proximity would be immediately available to community agencies adopting the project's approach, but its effect should be kept in mind, and similar or alternative means of increasing interdisciplinary communication should be considered.

Operational Characteristics of the Family Day Care Team

In the first year of the project, all three community coordinators made calls to recruit family day care homes. Once homes were inducted into the project, each community coordinator was responsible for some of the five homes, conducting assessments, screening, and training activities. In the second year, the three community coordinators and a student-intern social worker continued to recruit homes and to conduct activities in the ten family day care homes. At the commencement of the third project year, a family day care coordinator was appointed to serve the eight homes half-time. This person was a former community coordinator and educator who had operated with family day care homes since the first project year.

Family day care homes also had an advisory team, modeled after the interdisciplinary teams that operated in the centers. The team was composed of a nurse, social worker, and the project associate director (who did not conduct activities with the family day caregivers). The team, including the family day care coordinator, met every second week, to review children's needs and to discuss the family day caregivers' training and personal needs. The family day care coordinator reported on family day care activities, and the team made suggestions on any related topics.

All training and screening activities with the family day caregivers were conducted in the family day caregiver's home, by the family day care coordinator. The frequency of visits varied according to the needs and receptiveness of the individual family day caregiver. Visits occurred once every two to six weeks. Appointments were made in advance, and confirmed; calls to keep in touch were made between visits. The length of visit ranged from one to two hours. The agenda items of the family day care coordinator's visit were established by negotiation with the family day caregiver. They might include questions on the previous visit's topic; delivery of support materials, ideas, or suggestions; planned activities; negotiation of the next visit's topics and date; discussion of the caregiver's interests and needs. The visit provided an opportunity for personal interaction with the family day caregiver and interaction and observation of the children in the homes.

CHAPTER 10: A DESCRIPTION AND EVALUATION OF INTERVENTION TECHNIQUES

The evaluation procedure for each part of this section has two basic components: a description of the process and an assessment of its degree of implementation. Degree of implementation will be measured in terms of actual delivery of service and changes in center staff skills and interests.

Center Training Activities

The conceptual framework for the project's training approach as it was visualized at the beginning of the third project year is diagrammed in Figure 2. The focal point is the mutual goal-setting session between the project team and the center staff. Built around the needs and interests of the center staff and information from health and developmental assessments of the children, the sessions produced a set of goals, or more precisely, goal areas, for each center. Project service delivery was built around the goals, and was intended to produce changes in caregiver skills in those goal areas.

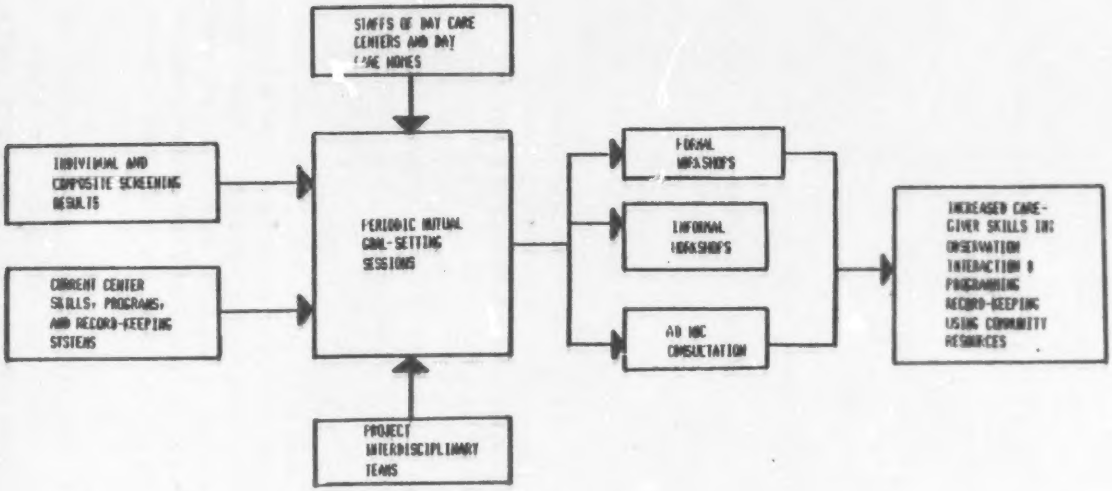
Because much of the actual goal-setting process was still being established during the course of the third year, one of the purposes of this section is to try to specify more completely the process as it evolved. Of particular interest are the specific linkages among the components of the project's training approach.

The training goals of the project were organized around a matrix of ten topic areas and six skill areas (see Figure 3) which identified the scope of potential project training activities. The matrix served as the basis for writing 60 item stems for a self-report skill assessment questionnaire to be administered to caregivers. Developed with intensive involvement of the project staff, the questionnaire was designed to serve as a needs assessment measure for project planning as well as an evaluation instrument for measuring outcomes. A validation report for the questionnaire appears in Appendix A2.

The matrix itself was an anchor point for relating questionnaire responses to project service delivery, since training activities could be organized into the same matrix format. Thus, it was possible to define the areas where the greatest amount of skill improvement should take place, based on the areas of focus for service delivery.

The data collected from the questionnaire consisted of 240 pieces of information--60 items for which four questions were asked (skill level, importance, project effectiveness,

FIGURE 2: CAREGIVER TRAINING AND CONSULTATION


STAFFS OF DAY CARE CENTERS AND DAY CARE HOMES
INDIVIDUAL AND COMPOSITE SCREENING RESULTS
CURRENT CENTER SKILLS, PROGRAMS, AND RECORD-KEEPING SYSTEMS
PERIODIC MUTUAL GOAL-SETTING SESSIONS
PROJECT INTERDISCIPLINARY TEAMS
FORMAL WORKSHOPS
INFORMAL WORKSHOPS
AD HOC CONSULTATION
INCREASED CARE-GIVER SKILLS IN:
OBSERVATION
INTERACTION *
PROGRAMMING
RECORD-KEEPING
USING COMMUNITY RESOURCES

* STAFF-STAFF
STAFF-CHILD
STAFF-PARENT

FIGURE 3 ITEM CONTENT MATRIX

TOPICS FOR CAREGIVER TRAINING

DEVELOPMENTAL SKILLS

HEALTH
SAFETY
NUTRITION
GROSS MOTOR
FINE MOTOR
CONCEPTS
COMMUNICATION
SOCIAL/EMOTIONAL DEVELOPMENT
PARENT INVOLVEMENT
STAFF INTERACTION

DESIRED CAREGIVER SKILLS

1.	KNOWLEDGE	(Basic information needed prior to application)
2.	OBSERVATION	(Recognizing, detecting, assessing, diagnosing specific behaviors or problems)
3.	PROGRAM PLANNING	(Matching activities to abilities, using materials appropriately, organizing ideas for program implementation)
4.	INTERACTION	(Building rapport or relationship, modeling, managing, presenting, implementing planned activities)
5.	USE OF COMMUNITY RESOURCES	(Finding resources appropriate to needs, facilitating family contacts with community agencies)
6.	RECORD KEEPING	(Developing and/or maintaining a record-keeping system to chart progress or changes, using records in planning)

request for help). Obviously some form of data summarization was necessary to make sense and use of the data.

The original matrix conceptualization of the questionnaire (an item written for each of six skill areas within each of the ten topic areas) was designed to produce stable estimates for each area--six for each topic area and ten for each skill area. Thus, the first step in data summarization was to construct indices for each topic and skill area. These indices were simply the mean score of the items for each skill or topic area. For example, the index for the topic of health was the mean of the six skill area items under health, while the index for the program planning skill area was the mean of all the program planning items across all ten topic areas. A separate set of indices was constructed for each of the four sections of the questionnaire--skill rating, importance, project effectiveness, and requests for help. (The indices for the requests for help section were the number of items for which help was requested rather than a mean rating, because there were only two possible responses on the help section.)

The questionnaire was first administered at the beginning of the the third year of the project to serve both as a pretest for measuring change and as a needs assessment for use by project staff. Appendices D1-4 report the means of these indices for caregivers, directors, and project staff. Directors and project teams filled out the questionnaire about the caregivers in their centers. Thus on the skill section of the questionnaire they reported how many of the caregivers in their center they felt were skilled in the area referred to in the item. The project teams did not always complete importance or effectiveness ratings.

Needs Assessment Results

Mean Skill Ratings (Appendix D1: scores range from 1 to 4.) As a group, caregivers saw themselves as having at least some skill in most areas. The weakest skill areas they reported were use of community resources and record-keeping. In fact, an examination of the individual items indicated that the items from these areas were the only ones in which more than half of the caregivers rated themselves at a low level of skill. The strongest skill areas were knowledge, observations, and interaction, all with means of 3.0. These results are consistent with what one would expect, since the caregivers were more likely to see themselves as proficient in those areas most connected to their day to day activities in the center. Variations in the ratings by topic area reflected the caregivers' perceived weaknesses in using community resources and record-keeping: higher rated topics were those few in which a majority of the caregivers did not rate themselves low on either use of community resources or record-keeping.

The directors as a whole tended to rate their centers as having most of the staff fairly skilled in most of the topic and skill areas. The weakest areas were use of community resources, record-keeping, and the fine motor area, which was consistent with the caregiver responses. These results were also consistent with the item results, in which a majority of caregivers rated themselves at the 3 or 4 level for most items, except those involving community resources and record-keeping.

Project ratings of the caregivers' skills tended to be somewhat lower than those given by the directors, particularly in the safety and nutrition topic areas and in the interaction skill area. These results suggest that the project staff may have operated from a different perspective than the directors, possibly having a broader view of what could be done versus what was currently being done in the centers.

Mean Importance Ratings (Appendix D2: scores range from 1 to 4.) Importance ratings were consistently high across all topic and skill areas for caregivers, directors, and project staff. The lowest ratings, relatively speaking, were for use of community resources and record-keeping, which was consistent with the lower skill ratings in these areas. The slightly lower importance rating for record-keeping was also consistent with occasional comments on the questionnaires that record-keeping was usually handled by the office staff. The fact that respondents rarely used the lowest response for importance suggests that the response choice might not have been worded appropriately. It also suggests that the questionnaire may have been addressing areas which were in fact recognized as important by day care personnel.

The high importance ratings given to almost all items by the project staff simply reflect the fact that the staff was involved in developing the items and that the items were developed from the goals of the project. For this reason some teams left this section blank, feeling that there was no real point in their response to this section. The slight variation in importance ratings by skill area, with record-keeping, interaction, and observation rated highest, reflected some of the project's priorities for the third year.

Mean Project Effectiveness (Appendix D3: scores range from 1 to 4.) This table is somewhat harder to interpret because there were a number of items for which respondents felt they had no real basis to rate the project's effectiveness--the area referred to in the item had not come up in their dealings with the project during the second year. The project staff were somewhat reluctant to make judgments in this area and responded to the section infrequently.

Those caregivers and directors who did have some basis for judging project effectiveness generally rated the project in the "somewhat effective" range, with directors tending to be somewhat more positive. Both directors and caregivers rated the project most effective in the knowledge and community resources skill areas. These were the two areas which probably involved the greatest project visibility in the second year, through workshops and screening follow-through. Project team ratings, where given, coincided relatively well with those from the centers, particularly with the ratings by caregivers.

Mean Number of Requests for Help (Appendix D4: scores range from 1 to 6.) For every item of the questionnaire at least half of the caregivers expressed an interest in receiving some form of help. This result suggests a wide variety of interests and needs among caregivers. It also suggests a willingness to accept any help which is free and fairly easily available. It is possible that this question could have been expanded to get at types or amount of help requested, at the expense of lengthening the questionnaire.

There were no consistent patterns among the means as related to the other tables. In some cases there appear to have been fewer requests for help where the project had been rated most effective (e.g., directors requested help in nutrition less often). In other cases the reverse was true (e.g., help with community resources was requested more often by caregivers). Requests for help may have reflected differing combinations of the other three sections of the questionnaire, and they may also have been related to differences between centers.

Development of the Need Index

In addition to serving an evaluation function, the Caregiver Questionnaire provided information which the project staff used in planning and conducting the individual center goal-setting sessions. The most straightforward use of the questionnaire would be simply to report the mean number of requests for help by center for each topic and skill area. However the caregivers in some centers tended to request help in almost every area, while caregivers in other centers tended to request little help. Thus, for the former, some procedure was needed to set priorities. For the latter some procedure was needed to suggest other areas for help.

One way to approach this problem was to devise a way of combining the information from the help, skill, and importance sections of the questionnaire. Presumably an area rated high in importance and/or low in skill for which help was requested would be of a higher priority than one which did not meet these criteria. This would call for a fairly straightforward summation of the three questions. However, some center staffs rated themselves as fairly skilled in most areas but were interested in help in their high-importance areas. This suggests that for some centers at least, skill level might not be as crucial a factor as importance or request for help, and, therefore, should be weighted less.

The format finally devised was a weighted combination of the skill, importance, and help ratings for each topic and skill index. The help ratings were given an essential weight of 3 (after adjusting for scale differences), importance a weight of 2, and skill a weight of -1 (the higher the skill the less the need). This produced a single "Need Index" for each topic and skill area. These Need Indices were then provided to project staff to help them plan for the goal-setting sessions.[1] Generally, the project staff used these indices as a starting point for going back to the actual item results.

Mutual Goal-Setting

The tone of the actual goal-setting sessions varied from center to center, and, as a result, so did the amount of direct use made of the questionnaire results. Some centers prepared their own list of goals and presented them to the project team. In other centers, the questionnaire results served as a starting point for discussion and specification of particular interests. Finally, some center staffs volunteered little information on their own, with the result that the questionnaire data were practically the only information used.

Two of the eight centers did not have goal-setting sessions per se. One of these centers worked with teen-aged parents of infants and operated somewhat differently from the other centers; the project did provide workshops for this center, but these were not based on any established goal areas. The second center was new to the project the third year and was offered the set of introductory workshops based on the four DIAL areas which the other centers received the second project year.

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[1] In actuality the project staff were originally given indices based on ranks instead of numerical scores, but these did not differ greatly from the results of the procedure described here.

The results of the goal-setting sessions for the remaining six centers are indicated in Appendix D5. For those goal areas that correspond directly to topic or skill areas from the Caregiver Questionnaire, the mean Need Index for the six centers is also indicated. The other goal areas are either combinations of topic areas or are specific interests within a topic area. Kindergarten readiness and developmental assessment, for example, represent particular applications of the four DIAL areas. The home visits and the parent make it/take it workshop goal areas involve particular interests in the area of parent involvement. The staffing protocols and use of foster grandparents goal areas are related to the use of particular community resources. Finally, the sex education and activities for the autistic-like child goal areas are specific interests in the social/emotional area. Thus, the goals which emerged from the goal-setting sessions tended to reflect the needs expressed on the Caregiver Questionnaire needs assessment; in general, the areas with the highest Needs Indices were chosen in some form as goals by most or all of the six centers. The number of centers choosing the safety goal area, despite its relatively low Need Index ranking, is reflective of an interest in a first aid workshop, which more or less straddles the health and safety areas; it also reflects a project goal of providing a safety checklist for the centers.

Service Delivery

The project approach to training in each of the goal areas consisted of varying combinations of workshops, resource materials, and consultation, as indicated in Appendix D6. Workshops were either offered to all centers at a central location or were provided individually to centers. Center workshops for a particular topic were similar in general content across centers but could be tailored to focus on the particular needs or interests of each center. The resource materials provided varied somewhat from center to center. All centers received copies of the Health and Developmental Intake Form, the Parent Activity Book, and the Safety Checklist. The amount of consultation also varied from center to center and often varied among individuals within centers as particular needs or opportunities appeared.

In addition to the workshops related to specific goal areas, a number of central workshops in the areas of concepts and communications were offered for any interested center staff.

The service delivery approaches indicated in Appendix D6 served as the basis for the Goal Area Questionnaire, a sample of which appears in Appendix D7. The questionnaire for each center was tailored to the specific goal areas and service delivery approaches for that particular center. The questionnaires provide, for each caregiver, an indication of how much training in a goal area was actually received, the extent to which the caregivers were able to successfully apply the ideas and information from the various approaches, and the extent to which they felt the goal was met. Where goal areas and approaches were similar across centers, the questionnaires allowed for combining information by goal areas across centers.

Workshops: During the five month period between early January and early June of the third project year, the project presented or arranged for 53 workshops on 28 topics. Eight of these workshops were presented by outside consultants contacted by project staff; the rest were designed and presented by the project staff. Each of the topic areas from the Topic/Skill Matrix were covered by one or more of the workshops. Each of the six skill areas appeared as goals in at least five, and usually ten or more workshops. Five centers had one or more staff members in attendance at 15 workshops. Two centers had one or more staff in attendance at eight workshops and one center had staff in attendance at five workshops. (Of these latter three centers, one had several goals which required resource materials and consultation rather than workshops. The other two were the two centers which did not take part in goal-setting.) The mean attendance at centrally-located workshops was 14, while attendance at center workshops varied with the size of the center staffs.

The above data indicate the scope and intensity of the project's training efforts, particularly if one keeps in mind that during this time project staff were providing additional training via consultation as well as carrying out follow-through activities for individual children with health or developmental problems.

Direct evaluation of the workshops was accomplished through the Workshop Evaluation Questionnaire (Appendix A15) administered to participants immediately following each workshop. The questionnaire consisted of three questions concerning the presentation and appropriateness of the workshop, nine questions involving the extent to which practical ideas were provided in the skill areas of the

Topic/Skill Matrix, and five open-ended questions designed to obtain more individualized reactions to the workshops.

Responses to the three presentation questions were overwhelmingly positive, with more than 90% of the responses[2] in the positive end of the scale (see Appendix D8). Thus, for these questions, any variation by the type of workshop tended to involve greater or lesser degrees of positive responses rather than negative versus positive responses.

Although, as noted above, ratings on the three presentation items were primarily positive, some variation did occur among types of workshops. Center workshops tended to be rated more positively more frequently than central workshops in terms of fit between topic coverage and caregiver needs (Item 3, see Appendix D9). This result provides evidence that project staff were in fact able to tailor center workshops to the specific needs and skill levels of the caregivers in a center.

Examination of the presentation items (Items 1-3) by topic area indicated that workshops in the areas of interpersonal relations (i.e., staff relations and social/emotional) were generally rated less positively relative to the other topics, while workshops related to the four DIAL areas and to health areas (health, safety, nutrition) were rated more positively (see Appendices D10-D12). These latter workshops tended to deal with more tangible information and materials, possibly making it easier to structure and focus these workshops and provide more concrete experiences for participants. Again, it should be emphasized that responses to all workshops were essentially positive.

Responses to the skill area items (Items 4-12) varied depending on the goals of each workshop. Generally, those areas which project staff indicated were goals for a workshop had more responses at the upper end of the response range for the item(s) corresponding to that skill area, (i.e., participants saw the workshops as providing more "practical ideas" for that skill area). This result is summarized in Appendices D13 through D21 in which response distributions for each item are displayed by grouped topic areas--health, developmental, and interpersonal. While, collectively, the workshops in each of these areas usually included goals from most or all of the six skill areas, there were generally certain skill areas which were goals for all or nearly all of the workshops within the grouped topic areas--program planning goals in the developmental areas, for example. The results in Appendices D13 through D21 reflect that clustering of workshop goals, and provide a reasonable way of summarizing the goal/item response match which almost always appeared in the evaluation of individual workshops. Thus, for example, participants in workshops in the developmental areas indicated that these workshops provided relatively more ideas for use in program planning, while participants in the various interpersonal types of workshops indicated these workshops provided more ideas for use in interacting with children. Participants in health-related workshops gave relatively more emphasis to the areas of knowledge, observation, community resources, and record-keeping. This correspondence between project intentions and participant perceptions was a necessary first step if intended training outcomes were to occur.

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[2] Because most caregivers attended more than one workshop, filling out more than one questionnaire, the questionnaire responses are not completely independent.

A second step would be an indication of intention to make use of the ideas from a workshop. Partial information concerning this step is provided by the responses to Item 16, an open-ended question asking what changes the participants would be likely to make or suggest as a result of what they learned in the workshop. While 43% of the participants did not respond to this open-ended question, those who did were more likely to suggest changes in skill areas for which they indicated the workshop provided more practical ideas (see Appendices D22-D30). This was particularly true for the areas of program planning, interaction, and record-keeping. Thus, to some extent at least, the workshop goals were being completed to the point that participants could recognize where they might be able to apply what they had learned.

Recognition of possible uses and statements of possible intent, however, do not necessarily indicate that what is learned from a workshop will actually be put to use. A measure of actual use was included in the Goal Area Questionnaires (Appendix D7), by asking caregivers who attended each workshop the extent to which they had successfully used any suggestions, ideas, or materials from the workshop. To avoid making the questionnaire overly long, these "use" questions were not separated by skill areas. Thus, for each workshop, the caregivers gave a global report of how successfully they were able to use whatever they learned from the workshop. Accordingly, a similar single index of "possible use" was built from the Workshop Evaluation Questionnaire by computing the mean of the nine skill area items for each respondent.

A direct comparison of these two indices cannot be made at the individual caregiver level, however. Because the workshop questionnaires were collected by project staff after each workshop, to ensure confidentiality respondents were required only to identify their centers. Thus, it was not possible to link the data from both questionnaires at the individual level. As a result, the comparison between the two indices can be made only by aggregating the data to the center level, where the data sets can be linked.

An additional limitation arises at the center level. Due primarily to staff turnover, there was a considerable drop in the number of caregivers making up the center aggregate for the Goal Area Questionnaire. Some of the caregivers who had originally attended the workshops were no longer at the centers at the time the Goal Area Questionnaire was administered. Thus, any test of relationship between the two indices rests on the assumption that even though the two data sets do not represent exactly the same people, they do provide adequate and comparable representations of each center as a whole.

Given the above limitations, the following results emerge:

1) All, or nearly all, of the caregivers who indicated that they had attended a workshop reported that they had attempted to use some aspect of what they had learned, and all, or nearly all, of these had at least partial success in using it (see Appendix D31);

2) At the center level a moderate, but significantly nonzero correlation (.39) appeared between the number of "practical ideas" generated by the workshop and the successful use of at least some of these ideas. The more a workshop was seen as providing ideas which could be put to use in the center, the more likely it was that some of these ideas would be reported to have been used successfully. When these use indices were further aggregated from individual workshops into topic areas (health, safety, etc.) the correlation was 0.46.

Thus, given that there are limitations to the strength of the conclusions that can be drawn, there is at least some evidence of a linkage between the intended training outcomes of the workshops and their actual occurrence. The ideas recognized by workshop participants tended to be in those areas which the project staff identified as goals. Furthermore, at least some of the ideas generated by the workshops were reportedly being used in the centers with some success.

Resource Materials and Consultation: The results for resource materials and consultation as delivery approaches were similar to those for the workshops (see Appendix D31). Most of the caregivers who reported receiving resource materials or consultation also indicated that they had used the ideas, suggestions, or materials they had received. For the most part, the majority of those who used the resource materials or consultation reported using it with general or high success. The actual numbers receiving resource materials and consultation tended to be smaller than the numbers attending the workshops. This was because these approaches tended to be more individualized as to centers and particular caregivers within centers.

These self-reports concerning use of training ideas, suggestions, or materials are supported in part by anecdotal reports from the project teams. For most of the goal areas, the project teams observed instances of use of project training in the majority of the centers choosing that goal area. This does not indicate frequency of use nor does it indicate that centers were using ideas from training with the degree of success the project would like. It does, however, indicate that project ideas were being tried.

Interrelation of Training Approaches: One purported advantage of the project's approach to training was that the team's frequent presence in the center would allow them to reinforce the learning from the workshops and resource materials with consultation and advice as the center put ideas into practice. Accordingly, one would expect that receiving and successfully using consultation should enhance the successful use of ideas from workshops and resource materials, and, consequently, increase the perception that the training goals have been met.

A direct test of this conceptualization was not possible. The numbers of caregivers involved were too small for any one goal area to produce any stable estimates of correlation among the consultation-received variable, the use variables, and the goal variable. However, given these small numbers and the unstable estimates within goal areas, a certain amount of consistency could be seen across goal areas. As a way of displaying this consistency, each caregiver's responses for each goal area were treated temporarily as if they were independent measures of workshops, consultation, and resource materials in general. Correlation coefficients were calculated (Appendix D32). It should be emphasized that because these measures are not in fact independent (i.e., most caregivers responded to more than one goal area), any significance tests based on a null hypothesis of independence are inappropriate. Thus, the correlation coefficients presented in Appendix D32 should be interpreted only as being suggestive of possible relationships which may warrant further investigation.

The correlations displayed in Appendix D32 suggest the following:

1) Receiving consultation appears to be positively related to reported successful use of ideas from training activities. Either consultation enhances the use of ideas, or using training ideas leads to increased consultation. In addition, receiving consultation appears to be positively related to the extent to which goals are perceived to have been met.

2) Whereas presence or absence of consultation is related to successful use of ideas and the perception of goals being met, workshop attendance and receiving resource materials are apparently not related to either. Thus, merely attending workshops does not guarantee that ideas from the sessions will be used successfully.

3) Successful use of ideas from training, whether from workshops, resource materials, or consultation, tends to be positively related to the extent to which goals are perceived to have been met.

Center Goal Attainment

Appendix D33 displays the proportions of respondents to the Goal Area Questionnaires who indicated whether the goals for a particular goal area were met no more than minimally, partially, or mostly/completely. In general, a majority of the respondents for each goal area indicated that the goal had been met at least partially. With a few exceptions, for any goal area no more than a third of the respondents indicated that a goal had been met mostly or completely.

Appendix D33 also displays similar information aggregated to the center level. For most of the goal areas, center staffs in general (i.e., a majority of the staff responding to the questionnaire) indicated that their goals had been met at least partially. A much smaller proportion of the centers indicated that their goals had been met mostly or completely.

It is important to point out that the center "goals" were rarely overtly defined in terms of outcome expectations, although definitions in terms of service delivery were more frequent. As a result, the caregivers' "covert" expectations could have shifted or increased with training, without our having a means to detect it. Operational definitions of goals were probably not possible at the outset of mutual goal-setting because in many cases the center staffs' conceptions of their needs were still vague. A second goal-setting session, possibly soon after the presentation of the initial workshops for a goal area, would probably be an appropriate time to define goals more specifically.

Another reason for the frequency of goals only partially met has to do with the time constraints of the project and the conflict between the project's demonstration/product development responsibilities and its service delivery responsibilities to the centers. The project was committed to developing and testing training procedures and materials in a broad range of areas relevant to day care. At the same time, the third year of the project was the final opportunity to work with the project centers on the specific needs of these centers. Thus, the tendency was to try to address as many of the needs as possible in the time left. This resulted in the partial meeting of a large number of center goals but also in the development of a fairly complete training package. In an ongoing training program, such as might occur if a community were to adopt the project's approach, it might be more effective to focus on a smaller, more specific set of goals within any one time span.

Changes in Caregiver Skills

Changes in caregiver skills from fall to summer of the third project year were measured using the Caregiver Questionnaire (Appendix A2). However, measurement of change was hampered somewhat by turnover in the center staffs and in a few cases by summer vacation schedules. Thus, of the 52 caregivers who responded to the Caregiver Questionnaire in the fall, only 26 were available to respond to the post-version of the questionnaire in the summer.[3] Additional caregivers were hired by the centers during the course of the year. Ten of these caregivers were in the centers long enough to have exposure to project training and, therefore, were also given the post-questionnaire.

Prior to examining the extent of change for those caregivers with pre- and post-questionnaires, this group was compared to the pre- only group and the post- only group to check for any radical differences. The mean topic and skill area indices for each set of caregivers are presented in Appendices D34 through D36. On the basis of a Hotelling's T-square test, the pre-post group did not differ significantly from the pre- only group in skill, importance, or project effectiveness ratings. Thus, the "dropout" group of caregivers was not substantially different from those who were available for both the pre- and post-questionnaires.

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[3] Three caregivers were dropped from subsequent analysis because of unusual response patterns. These three caregivers had each been with their centers for ten or more years, whereas most caregivers had been with their centers for a maximum of five years. Their "outlier" responses on the Caregiver Questionnaire tended to mask relatively consistent experience-related trends for the rest of the caregivers, producing, for example, curvilinear trends when for the bulk of the caregivers the trends were linear. These three constituted too small a group to be examined separately, and, in the interest of confidentiality, they probably should not be. As a result, they were simply not included in the data analysis.

When the pre-post group is compared to the post- only group, they do not differ in their skill ratings. However, they do differ in their importance ratings and ratings of project effectiveness for the set of six skill area indices: the post- only group gave higher ratings in both cases. Differences for the set of ten topic area indices were not significant for either importance or project effectiveness, but the direction of the differences were the same: the post- only group gave higher ratings in both importance and project effectiveness. One possible explanation for these differences is that the post- only group, being newer to their centers and possibly less experienced as caregivers than the pre-post group found the training from the project staff to be helpful during their adjustment to their jobs, and thus tended to see the project as more effective.

Changes in the pre-post group's skill self-ratings from the pre-questionnaire to the post-questionnaire were consistently positive although not statistically significant (based on a series of pair-wise t-tests) except for the health and safety topic areas and the knowledge and community resources skill areas. Importance ratings of the topic and skill areas remained essentially the same. They were high to begin with and remained high. Ratings of project effectiveness were consistently lower on the post-test, although the differences were not statistically significant except in the social/emotional topic area. If, however, one looks at change in effectiveness only for those centers which chose a topic or skill area as a goal, this negative trend is reversed in three (health, gross motor, and fine motor) of the seven areas with group sizes large enough to test, and was reduced in three additional areas (social/emotional, parent involvement, and community resources).

Given that the training which was offered varied from center to center both in goal areas and in extent of application, one would not necessarily expect a great deal of change across all areas and across all caregivers. The more pertinent question may concern the extent to which the degree of implementation of training for a goal area, i.e., application in the center and meeting of goals, affected responses to the Caregiver Questionnaire. Thus, the next logical step is to relate Caregiver Questionnaire responses to Goal Area Questionnaire responses.

As indicated earlier, attempts to look at interrelationships of variables within goal areas were not possible as numbers were too small to produce stable estimates of correlation. Accordingly, as before, the set of responses for a caregiver within a goal area were treated as if they were separate cases, e.g., if a caregiver responded to five different goal areas, this would be translated into five "cases"--sets of responses to "workshops in general" or "skill in general." Again, the correlations resulting from this procedure should be treated only as descriptive. The violation of independence assumptions invalidates any tests of statistical significance.

These correlations are presented in Appendix D37. The figures are based on all 10 topic areas and the community resources skill area. As might be expected, the correlations between the Caregiver Questionnaire and the Goal Area Questionnaire are not as high as those _within_ items on the Goal Area Questionnaire. However, the patterns of correlations in Appendix D37 suggest the following:

1) Neither the post skill ratings nor the change in skill ratings appear to be related to amount of training received or used. Marginal positive relationships (notable more for their contrast with other correlations in the set than for their actual size) are indicated between the extent to which goals were met and the post skill and change in skill ratings. These results may be due in part to the idiosyncratic nature of self-report ratings. For some people, self-perceptions of skill may increase with training, while others may become more aware of how much more they have to learn, decreasing their perceived skills. Additionally, low skill was not the sole basis for selecting goal areas. Importance and expressed interest were, in fact, given more weight. Thus, a caregiver already relatively skilled in an area might have attended workshops, successfully used ideas and materials, and had her/his goals met without any change in perceived skill on the scale available on the questionnaire.

2) There is a positive relationship between the Need Index constructed from the pre-Caregiver Questionnaire and the amount of consultation received. There may also be a positive relationship between the Need Index and workshop attendance and between the Need Index and successful use of ideas from consultation. These relationships in

part reflect the use of the needs assessment for determining goals in the first place. They may also be indicative of greater motivation to participate in training.

3) There appears to be a positive relationship between post- importance ratings and the successful use of training ideas from workshops, resource materials, and consultation. This relationship may suggest that seeing training ideas used successfully increases the perceived importance of the area in which they are applied. It may also suggest, since importance ratings stayed essentially the same from pre- to post-questionnaire, that caregivers may be more motivated to use training in areas they perceive to be important.

4) Ratings of project effectiveness appear to be positively related to the amount of consultation received, the successful use of training ideas, and the extent to which goals were perceived to have been met. Thus, perceptions of the effectiveness of the project's training efforts are related to their actual successful application in the centers.

The responses to the Caregiver Questionnaire by the directors and by the project teams are indicated in Appendices D38 through 40. In rating the overall skill of the caregivers in the centers, neither the directors nor the project teams indicated any consistent increases or decreases in caregiver skill. Generally the ratings were about the same as they were on the pre- form of the questionnaire. This may have been partially the result of staff turnover in the centers. Directors' importance ratings declined somewhat from pre- to post-questionnaires, but still remained basically high.

Directors' ratings of project effectiveness tended to decrease from pre- to post-questionnaires, much as they did for the caregivers; however responses generally were in the somewhat to moderately effective range. Project team ratings of their own effectiveness on the post-questionnaire (teams frequently were reluctant to respond to these items on the pre- forms) were quite similar to the directors' ratings except for parent involvement, which project teams rated higher, and social/emotional and community resources, which the directors' tended to rate higher.

Summary: Aside from the difficulties with self-report scales mentioned earlier, the results reported above may be reflective of the relatively short time span between training and final data collection. The last workshops were given in early June, with final consolidation sessions with centers running through July, while final data collection occurred in July and August. Thus, caregivers were applying their training in the centers and could recognize project effectiveness in providing the training, but they had not had sufficient time to consolidate and build what they had applied into substantial increases in perceived skill. However, small but consistent gains did occur. The project teams frequently expressed frustration during end-of-project interviews that, although progress had been made in general areas, more time was needed to effect more permanent change. The linkages described above, from needs assessment to goal-setting to training delivery to training application, indicate that progress was indeed being made. They also indicate that where consultation was used to facilitate and reinforce the application of training, the effectiveness of the training was likely to be greater.

These linkages are summarized in a revised version of the training conceptual framework diagram, Figure 4. The concept of building trust and reciprocity, while new to the diagram, has always been a part of the process. Evidence of the time needed to build rapport is suggested by the experiences of the team working with the center which only joined the project at the beginning of the third year. They felt by the end of the year that the center staff were beginning to open up and respond to the project at about the same level that the other centers did at the end of the second project year. Given another project year, they would be ready for mutual goal-setting.

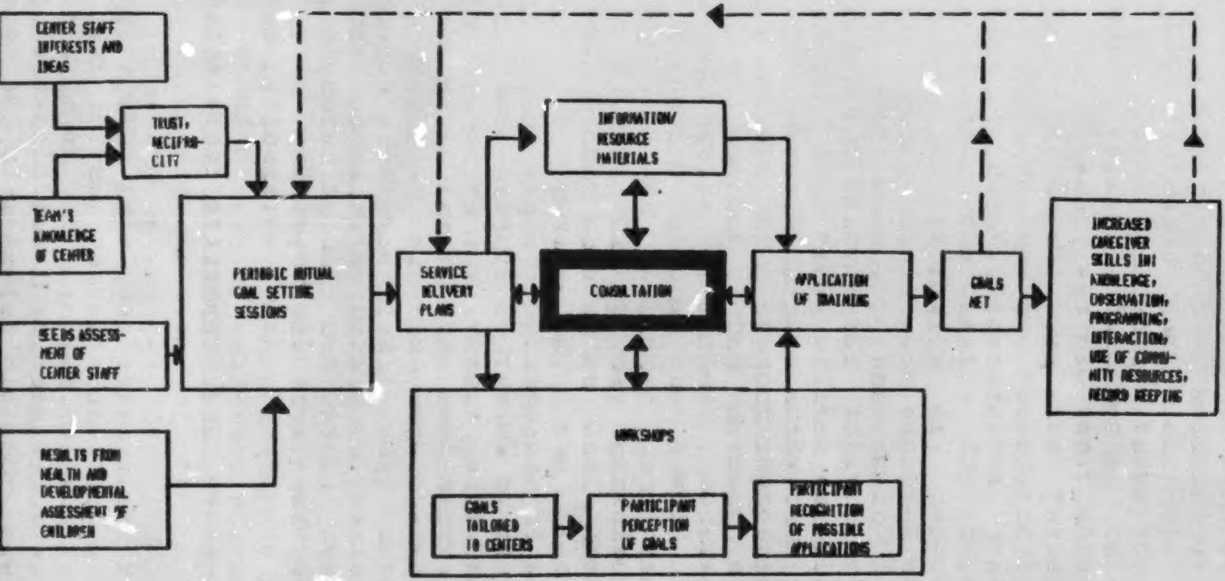
Consultation is indicated as playing a central role in facilitating the application of training and in the meeting of goals. As ideas are used and goal attainment is assessed, the process can recycle back to mutual goal-setting and/or service delivery planning. This recycling may be particularly important given the high staff turnover rates in day care; needs have to be continuously reassessed as new staff move in. Periodic repetition of workshops (one function of the project's central workshops), easy access to standard information resources (e.g., workshop handouts on file) in the centers, and supportive consultation can be of help here.

This report has provided at least some evidence for all of the linkages in the figure except the final one. Establishing that link appears to require more time for skill changes to be effected or the addition of some as yet unspecified steps, possibly relating to the nature of self-report ratings.

Family Day Caregiver Training Activities

A description of the training and consultation services provided for family day care homes and of the methods used to deliver these services is given in Chapter 7. The goal

FIGURE 4: CAREGIVER TRAINING AND CONSULTATION (REVISED)


CENTER STAFF INTERESTS AND IDEAS
TRUST, RECIPROCITY
TEAM'S KNOWLEDGE OF CENTER
PERIODIC MUTUAL GOAL SETTING SESSIONS
NEEDS ASSESSMENT OF CENTER STAFF
RESULTS FROM HEALTH AND DEVELOPMENTAL ASSESSMENT OF CHILDREN
SERVICE DELIVERY PLANS
INFORMATION/ RESOURCE MATERIALS
CONSULTATION
APPLICATION OF TRAINING
GOALS MET
INCREASED CAREGIVER SKILLS IN: KNOWLEDGE, OBSERVATION, PROGRAMMING, INTERACTION, USE OF COMMUNITY RESOURCES, RECORD KEEPING
WORKSHOPS
GOALS TAILORED TO CENTERS
PARTICIPANT PERCEPTION OF GOALS
PARTICIPANT RECOGNITION OF POSSIBLE APPLICATIONS

areas these caregivers chose to concentrate on are given in Appendix D42.

Changes in Family Day Caregiver Skills

Changes in family day caregivers' skills from fall to summer could not be reliably measured from the Caregiver Questionnaire results, due to administration difficulties encountered in both the fall and summer interviews. Items had to be explained to several of the family day caregivers, indicating a lack of familiarity with some of the terminology, or possibly lower reading ability than that of the center caregivers. Also, overall, the family day caregivers rated themselves as highly skilled on the pre-questionnaire, which, besides being dubious when compared with the Observation Checklist data, did not allow room for significant changes in the mean skill ratings on any post-questionnaire data. The post-questionnaires were administered, but comparison of the pre-post ratings was abandoned as statistically futile.

There were several factors inherent in the training of family day caregivers that permitted a different approach to measuring the extent to which training goals were met. Family day care activities were on a later time schedule for the project than center-related activites, owing to the greater time necessary to develop rapport and reciprocity with the family day caregivers. The additional time permitted the project to utilize feedback about the measurement procedures used in the centers. And as the pre-questionnaire data from the family day caregivers was not reliable, as previously discussed, pre-post comparisons could not be reliable measures of the training goal effects. So the Goal Attainment Scaling* method was considered the appropriate measurement approach.

The family day care coordinator constructed, for each goal for each family day caregiver, a scale for goal attainment, assessing by objective observation the relative attainment of specific individualized training goals.

Goal Attainment Scaling was explicitly incorporated into the training process, and the evaluation device specified unique aspects of the individual family day caregiver's training goals. In order to construct a Goal Attainment Scale, the major areas in which training was expected to have an impact were identified. The goal areas were assigned equal weights for any individual family day caregiver, because they were regarded as contributing equally to the overall goal of caregiver training.

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*Kiresuk, Thomas J., and Sherman, Robert E. Goal Attainment Scaling: A General Method for Evaluating Comprehensive Community Mental Health Programs. Community Mental Health Journal, 4, 443-453, 1968.

For each goal area a scale was constructed representing a series of possible outcomes related to the goal; the content of each scale was tailored to each goal area. The idiosyncratic nature of the scaling attended to the differences among the homes' goals and conditions. A 3-point scale was chosen, specifying three progressively more favorable levels of possible outcomes in relation to each goal area. The lowest was the "most unfavorable outcome thought likely." The second was the "expected level of success." The top level was the "best anticipated success." (In Goal Attainment Scale literature, a 5-point scale is recommended. However the family day care coordinator's estimated outcomes for the family day caregivers were so constrained that three points were expected to differentiate sufficiently.) For example, the scale for a goal area "Program Planning for Fine Motor Activities" specified a range of outcomes from "read written materials provided by project" to "find materials, plan activities for children." "Try out a new activity from project suggestions" was chosen as the expected outcome. The outcome statements were specific (so expectations were clear), observable (so there was little confusion as to the level of outcome that actually occurred) and realistic (so the scale was meaningful to the family day caregiver's particular situation). The anchor points on Goal Attainment Scales were subject to review by the family day care team. Meaningfulness and appropriateness of both scales and anchor points were subject to review by the evaluator. At the end of the project's involvement with the family day caregivers, the scale levels that best described the outcome for each caregiver at that time were checked. Observations of and discussion with the family day caregiver by the family day care coordinator formed the basis of this check. Each scale was scored at only one level, resulting in the generation of a summary Goal Attainment Score and a Goal Attainment Change Score.

The Summary Goal Attainment Score was a global index of the degree to which expectations of the training program were met. It was generated by transforming the scores on the individual scales of a goal attainment follow-up guide into a single numerical value. Essentially it was a simple average of attainment on all scales for each individual family day caregiver. The resulting value was multiplied by 10 and added to 30, to spread the scores between 30 (skill level unchanged) and 60 (achievement of best possible outcome). A Summary Goal Attainment Score of 50 indicated that a family day caregiver had, on the average, exactly attained the "expected level of success."

Results of the seven family day caregivers' attempts to meet their training goals are in Appendix D42. All family day caregivers made some gains toward their training goals: five did not reach the midpoint ("expected level of success"); and two exceeded the expected level.

The Goal Attainment Change Scores indicated how much difference there was between a family day caregiver's status before and after the training period. The choice of the levels was tailored to the situation for each family day caregiver. The change score was determined by summing the number of scale points along which a family day caregiver had advanced:

0 points = skill level unchanged.
1 point = 1 goal attainment level per point.
3 points = achievement of best possible outcome.

An average was determined, as the number of goal areas varied for family day caregivers. The numbers generated on any two training Goal Follow-up Guides were incomparable, as the goals were highly individualized. However, similar goal topics were scored for attainment to examine the relative success of the various goal areas (see Appendix D41). The change scores for individual caregivers ranged widely, from 0.5 average (minor change) to 2.7 (nearly the best possible outcome on all scales).

The range in both attainment and change scores reflected the diversity of family day caregivers' pre-training skills and motivation to participate in training activities. The distribution of scores among the family day caregivers suggested that the goals had been set realistically. However progress was made by all family day caregivers over the short (four month) period. When examined by goal area, several results emerged:

1) Developmental areas were areas of improvement (knowledge, program planning, interaction);

2) Nutrition was a goal area in which there was ample change;

3) Community resources was a goal area in which there was a diverse but overall minimal change.

Considered in the light of the goal-setting process, these results were reconcilable: use of community resources was a project goal, especially the linking of family day care homes to a project center, and hence, was an actively promoted goal area. While the family day caregivers were not initially averse to the goal area, it was suggested by the family day care coordinator to the family day caregiver in half of the cases where it was a goal, and therefore was not high on the caregivers' own priorities. In light of the highly variable motivation for training and the pre-intervention status of the use of community resources, there may have been much ground work necessary for achievement of this goal (e.g., awareness development).

Follow-through

Along with the project's use of training as a form of long-term follow-through, the project's other major focus was immediate follow-through on specific children with problems identified by the formal health, developmental, or dental assessment, or by more informal observations by parents, caregivers, or project staff. The components of this process are described in the project report. In addition, a diagrammatic representation of the process is presented in Figure 5.

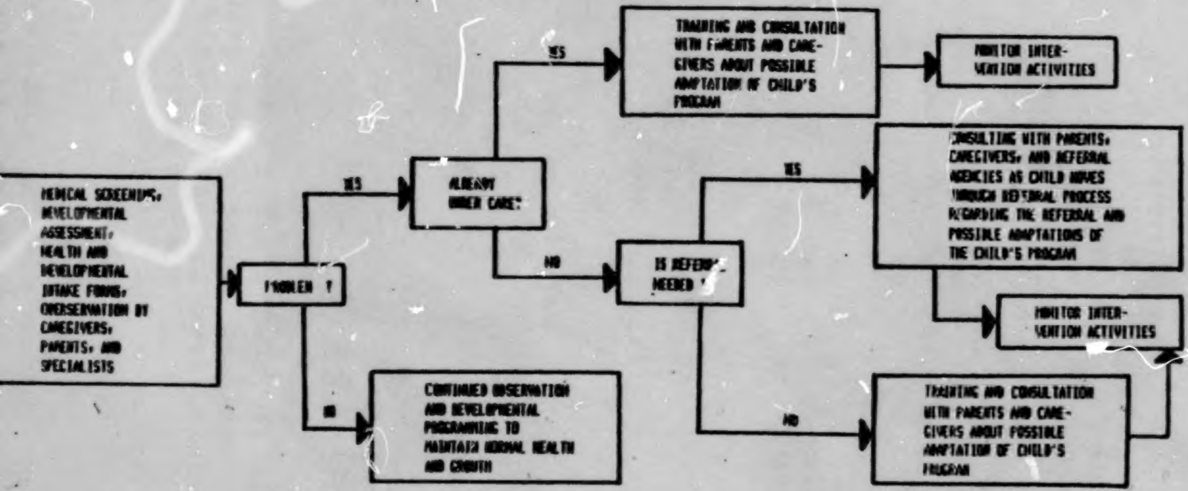
The data for this section were drawn from the project staff's recorded notes of their follow-through efforts. We intend to describe the patterns and outcomes of the project's follow-through activities with regard to the types and levels of seriousness of the problems.

Over the three years of the project, 616 children received one or more health, developmental, or dental assessments or had problems found by informal observation. (See Appendices B1-2 and B8-9 for breakdowns by assessment type.) Some 548 "problems" received follow-through attention, although, as will be seen, many of these were more informational needs than problems (e.g., lists of medical resources for a parent). Thus, for purposes of this description, a much broader interpretation of "problem" is used in order to examine the full range of the project's follow-through efforts.

The problems which arose from the various assessments and observations of children can be divided roughly into five categories (see Appendix B11) in terms of implications for follow-through: "nonproblems," initial concerns resolved to nonproblems, problems already under care, problems which were not referrable but which required follow-through, and referrable problems.

"Nonproblems" (frequency: 123; 22.5% of the "problems" found). This category did not entail any currently active or acute problem for the child, but usually involved passing on information (see Appendix B12). The most frequent example was providing parents with a list of dental or medical resources when a child's health history form indicated the family did not have a regular dentist or physician. Of the 123 "nonproblems" found over the three

FIGURE 5: FOLLOW-THROUGH PROCEDURE


MEDICAL SCREENINGS, DEVELOPMENTAL ASSESSMENT, HEALTH AND DEVELOPMENTAL INTAKE FORMS, OBSERVATION BY CAREGIVERS, PARENTS, AND SPECIALISTS
PROBLEM ?
YES
NO
ALREADY UNDER CARE?
YES
NO
TRAINING AND CONSULTATION WITH PARENTS AND CARE-GIVERS ABOUT POSSIBLE ADAPTATION OF CHILD'S PROGRAM
MONITOR INTER-VENTION ACTIVITIES
IS REFERRAL NEEDED ?
YES
NO
CONSULTING WITH PARENTS, CAREGIVERS, AND REFERRAL AGENCIES AS CHILD MOVES THROUGH REFERRAL PROCESS REGARDING THE REFERRAL AND POSSIBLE ADAPTATIONS OF THE CHILD'S PROGRAM
MONITOR INTER-VENTION ACTIVITIES
TRAINING AND CONSULTATION WITH PARENTS AND CARE-GIVERS ABOUT POSSIBLE ADAPTATION OF CHILD'S PROGRAM
CONTINUED OBSERVATION AND DEVELOPMENTAL PROGRAMMING TO MAINTAIN NORMAL HEALTH AND GROWTH

years, 63% involved providing families with a list of resources.

Another type of "nonproblem" involved drawing the center staff's attention to recurring or chronic problems, such as allergies, asthma, or ear infections, indicated in the child's health history but not causing the child any difficulty at the time of the screening. In the case of recurring ear infections, for example, the center staff could be alerted to allow for possible hearing loss when the child had a cold. Thirty-two instances (26%) of this sort of follow through activity occurred, 10 of them involving a history of ear infections. There were an additional 14 (11%) instances in which an entry concerning a child's health history was made in the project's follow-through notes with no particular need for follow-up indicated.

Most "nonproblems" came out of the health assessment process, although in a few instances parents directly requested lists of resources. Nearly all (98%) of the follow-through activities for "nonproblems" occurred in the second and third project years.

Initial concerns resolved to nonproblems (frequency: 63; 11.5% of all problems found). This category involves problems found on an initial assessment which, after retesting or reconsideration, were determined not to be problems (see Appendix B13). About 50% of these were children initially assessed as down in one or more DIAL area for whom English was a second language or for whom center staff indicated that the child's DIAL performance was not reflective of the child's day to day behavior in the center.

Another 25% of these problems were referred for retesting, usually for medical lab tests, with these second tests coming out negative (reDIALs after several months are not included here).

This category also included a small number of initial problems which were subsumed under other problems. One example of this was a child down by DIAL criteria who also failed a hearing test. The project staff focused their follow-through on getting care for the hearing problem; once that was cleared up the child performed normally on the DIAL.

Problems in this category were distributed fairly evenly across the three project years, relative to the number of children assessed each year.

Problems already under care (frequency: 70; 12.8% of all problems found). About 55% of the problems already under care required no particular follow-up by the project staff (see Appendix B14). For 20% of the problems under care the project provided fairly brief follow-up, usually consisting of discussing the problem with the center staff or with the parents. For 24% of the problems under care, the project staff provided more extensive follow-through, checking periodically with the parents regarding the child's progress, working with the center staffs concerning program adjustments, or in some cases working with the parent and child to help carry out the treatment.

While the bulk of these problems turned up on one of the formal assessments, about 15% of them were brought to the project staff's attention by center staff or parents. All but one of these were followed-through by the project staff.

Nonreferrable problems (frequency: 145; 26.4% of all problems found). This category included problems which were not under care and which were not, at the time, serious enough for referral (see Appendix B15). Most of these were developmental problems (62%) (e.g., a child down on one or two DIAL areas); or behavioral problems (22%), frequently brought up by caregivers or parents. About 14% were health problems, usually involving colds or mild infections; the follow-through for these was usually a discussion of treatment with the parent with instructions to see a doctor if the condition worsened. The follow-through for behavior problems (e.g., separation anxiety) usually involved one or more consultations with the parent and/or with the caregivers to come up with a strategy to deal with the problem.

The developmental problems were discussed with center staff during the DIAL feedback sessions. These discussions usually resulted in a set of suggested activities for the caregivers and the parents to work on with the child. (These discussions also often suggested areas for more formal caregiver training.) In some cases (37%), particularly when the DIAL was administered early in the year, the decision was made to observe the child and possibly retest later to see if the child improved after having more time to adjust to the center. When the child was down in two DIAL areas or down by DIAL criteria (but not referred) the most typical approach was to observe and retest later or to provide more extensive consultation. For children down in one area only the typical approach was a brief consultation with center staff and/or parents to suggest activities for the child.

While more than half of all nonreferrable problems were found during the DIAL assessment, 26% were identified through observations or requests by parents, caregivers, or project staff.

Most of the nonreferrable problems (85%) were found during the second or third project year. The observation/retest strategy and the more extensive consultations occurred only during the second and third years.

Referrable problems (frequency: 147; 26.9% of all problems). These were problems deemed serious enough to require referral. Ninety percent (all but 14) of these were actually referred; those that were not referred were, for the most part, lost to follow-up (e.g., moved out of town), the parents had halted the process, the problem had improved, or referral efforts were underway at the time of data collection.

The referrals for each problem type are displayed in Appendix B16. The most noticeable figure is that 46.6% of the referrals were for dental problems, 82% of these being found during the on-site dental screen the third year. Hearing problems accounted for 13.5% of the referrals, immunizations accounted for 10.5%, and other medical problems for 15%. Developmental problems accounted for 7.5% of referrals although they accounted for 29% of all problems combined across all levels; this may be primarily because the decision to refer or not to refer is more clear-cut for medical and dental problems than it is for developmental problems, as are mechanisms for providing treatment. This suggests the value of working through vehicles such as day care to remediate developmental problems which are not yet serious enough for referral under present practices.

The amount of project staff effort necessary to follow-through on referred problems varied. For 75% of the problems the procedure involved one or two follow-up phone calls or other contacts to check on whether appointments were kept; this was particularly true of fairly standard medical, dental, or immunization appointments. Eighteen percent of the referred problems required relatively frequent efforts by the project staff to follow through. These were often cases where parents were hard to reach, or were somewhat confused about what was needed; again, these usually involved dental or medical referrals.

Nine referred cases (6.8%) required intensive, almost continuous effort on the part of the project staff. Seven of these 9 cases were developmental referrals. Thus, 7 of the 10 developmental referrals required intensive follow-through. In 4 of these 7 cases there were substantial delays related to contacts with parents--difficulties in contacting them or reluctance on their part to follow-through. In 6 of the 7 cases there were substantial delays getting services from the agencies involved--usually public school diagnostic services.

Final Resolutions of Follow-through Efforts

The final resolutions of the project's follow-through efforts for referred problems are indicated in Appendix B17. For referred problems, 53.5% were under appropriate care or were remediated, while for an additional 4.5%, follow-through was continuing at the time of final data collection. Twenty-one percent of the referred problems were lost to follow-through--the children had moved or left the center,[5] project staff were unable to contact the parents, or the parents had stopped the process. For an additional 7.6%, the project notes indicated that no further follow-through was needed: these were typically medical or dental referrals for which sufficient progress was being made towards getting treatment. The remaining 13.6% of the referred problems showed no particular resolution in the project notes, but they were also fairly standard medical and dental referrals and, in most cases, probably did not require further follow-through.

Four of the cases lost to follow-through were developmental referrals which had required intensive project effort; two of the seven intensive developmental cases were under care, while, for one, follow-through was continuing at the time of final data collection. Of the four lost to follow-up, one had been evaluated, two were scheduled for treatment, and one was withdrawn by the parents.

For nonreferrable problems (Appendix B18), 25.5% were under care, improving, or remediated, while for an additional 2.8%, follow-through was continuing. Ten percent of the problems were reported lost to follow-through. The larger proportions of problems for which no resolution was indicated has to do with the nature of the problems and the consultation given. For children down in only one of the three DIAL areas other than communications, or with children for whom it was suspected that the problem was more with the screening situation itself than with developmental delay, the usual approach was to suggest a set of activities and/or continued observation. Unless the problem was brought up again as being of continuing concern, additional entries were usually not made in the project's follow-through notes. Likewise, if a caregiver or parent requested consultation concerning a short-term behavior problem, for example, no follow-through was carried out beyond the initial consultation unless the caregiver or parent requested it. Thus, for a number of relatively mild problems, the only action needed was relatively brief preventive or supportive consultation.

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[5] Project staff attempted as much as was possible to continue follow-through for children who had left the center but who remained in the community.

Summary: Among the most salient aspects of the project's follow-through approach is its capacity to deal with problems which have not reached the referral stage. Project teams were able to alert centers to the implications of conditions indicated on the Health and Developmental Intake Forms which might affect the child's behavior or welfare while in the center; and they were able to provide information to the centers about adjustments or support they could provide for children with problems already under care. The interdisciplinary approach enabled the project to assess the implications of problems from a variety of angles--the developmental and social/emotional implications of a hearing problem, for example.

Working in the centers provided access to a set of observers (in addition to the parents) who saw the child on a day-to-day basis and could, thus, provide information useful for interpreting the validity of the results of the developmental assessment for a given child. The teams were able to work with center staffs to provide supportive, preventive programs, both in the short run for specific children with identified, nonreferrable problems, and in the long run by providing training for center staff. In addition, the on-site accessibility of the teams allowed them to respond to a number of informal requests from caregivers or parents for consultation or information.

For referred problems, the project teams were able to follow most problems beyond the initial appointments, which is in most cases the stopping point for the traditional EPSDT follow-up process. For intensive follow-through efforts, the teams were able to provide continuity by following the process even as it moved among several community service agencies. Working in the centers also provided an additional source for contacting parents.

The value of the project's follow-through approach may be most apparent for developmental problems, where problem identification typically is not clear-cut and services are often difficult to obtain. Working with caregivers and parents, the teams could help to build preventive programs for low-level problems, and, where referrals were needed, they were able to help parents and children obtain the services needed.

Parent Involvement

Parent involvement was both a hidden and an open agenda item in the project's training effort. It was an explicit goal for all of the centers involved in goal-setting; it was also an implicit goal in most, if not all, of the training in the other goal areas. For the most part, however, the project staff indicated at the end of project interviews that, while they had a sense of having helped center staff to think more about parent involvement, they did not see any real movement toward increased parental involvement in most of the centers. This is borne out in the results of both the Goal Area Questionnaire and the Caregiver Questionnaire. Most of the caregivers responding to the Goal Area Questionnaire saw the parent involvement goals as being no more than partially met (see Appendix D33), although there was somewhat more liklihood that they would perceive the goal as being met if they had used the project training ideas successfully. Little or no change was indicated for this goal area in either skill, importance, or effectiveness ratings (see Appendices D34-36), on the Caregiver Questionnaire.

The fact that all centers adopted parent involvement as a goal indicates some recognition of the need for increased parent involvement (project staff also lobbied for the goal prior to mutual goal-setting, however), and all centers, of course, already had some form of regular contact with parents. However, like any of the interpersonal relations areas, parent involvement is somewhat more elusive as a training area than, for example, the gross motor or fine motor areas, where specific program activities can be put into effect.

Parent involvement was a given in the project's follow-through process, as parents were notified of all screening results and recommendations and were, of course, part of any referral decisions. Routine follow-up phone calls fairly often generated discussions of other problems, particularly in the health and behavioral areas. Frequent parental delays played a role in only about 5% of the total follow-through problems, although they occurred in about 10% of the referred problems. Thirty percent of the frequent delays were for developmental problems. In many of the developmental referrals and in the more difficult health referrals, project members played an advocate or supportive role for parents.

In summary, project staff generally were able to facilitate parent involvement in their own follow-through activities. However, for many, though not necessarily all centers, parent involvement goals were no more than partially met.

Developmental Programming

As indicated in the description of the follow-through process, developmental programming was a basic part of the feedback sessions on the DIAL results given for each center.

Suggestions for program activities were made for all children with delays on the DIAL. In the third year, all parents received copies of the parent activity book, Big Hands, Little Hands Together; parents of children down in one or more DIAL areas were referred to specific activities. For all children with serious DIAL delays, there were more extensive consultations with parents and caregivers. The results of the follow-through on DIAL problems (Appendices B20 and B21) indicated that programs were in progress or completed for a relatively large portion of the children down by the DIAL criteria and for a moderate portion of the children with lesser problems.

There were no specific center goals for developmental programming. However, a majority of the centers with goals in the gross motor and fine motor areas felt their goals had been met (see Appendix D33), and a majority of the caregivers in the center requesting developmental assessment as a goal area felt that their goals had been met. The mean successful use for the workshops in the four developmental areas and for the developmental assessment workshop were all high (see Appendix D31). As was generally true with the Caregiver Questionnaire, there were consistent but small increases in the mean skill ratings related to the developmental areas and to program planning (see Appendix D34).

In summary, there is fairly good evidence that developmental program ideas were being put into general use in the centers and that for children down in one or more DIAL area specific activities were being suggested. For children with relatively serious developmental delays there is evidence of specific programs being put into practice.

Utilization of Community Resources

Data for this section were gathered from interviews conducted at the end of the third year, which focused on a list of 92 resources (see Appendix E2) in the community that cater to day care facilities and preschool-aged children and their families. This list of resources was developed with the help of project staff and records. Sources included a list of the 21 agencies interviewed in the first year, project documents that listed those resources used by or recommended to the centers and homes in the project, as well as a selection of other agencies taken from a publicly-available listing of resources in the county. The list did not represent a target group of resources, but rather a fairly exhaustive list of those resources used by, recommended by, recommended to, or available to the project centers and homes. This list of resources was grouped roughly according to the primary service provided: health, education, human service, or multiservice agencies.

In order to make the task specific to the actual use of resources, the services offered by each resource were included on the list. This was done to more accurately portray the depth of utilization of resources. Hence the data referred to services across 96 resources (4 were added to the list by directors during the interviewing process) so that one agency could be responded to more than once. A shortened form was developed for family day care homes, corresponding to the resources identified by the family day care coordinator of the project as having been used or suggested to the family day caregiver. The shortened version was necessitated by the family day caregivers' few contacts with resources, as well as by sensitivity to a previously-encountered problem of reading skills with these persons that indicated the desirability of a brief task with due attention to validity in the shortened list, so that center and home contacts with community resources would be comparable and could be combined.

Project Utilization of Community Resources

The project was in contact with a wide range of community resources for the planning of activities and the delivery of services to the centers and homes. Many of these contacts were already established at the start of the project, as some project staff members were former key resource personnel in the county, and were aware of the services available from the interagency pool.

The data for this section were drawn from the project staff's responses to the community resources checklist, the recorded minutes of their team meetings, and follow-through notes for specific children. The intent of this section is to describe the frequency, range, and purposes of project contacts with community resources, especially those contacts that were on behalf of the centers and homes in the project. Data from the community resources checklist will be the most complete, because the list itself is based on all the available sources of information concerning project use of resources. The resource use figures from the minutes of team meetings and from follow-through are, consequently, somewhat lower and are presented following the checklist data primarily to provide additional descriptive information about the nature of project use of community resources.

The different needs and preferences of each center led to somewhat individualized approaches by the project teams to facilitate links between community resources and centers and homes. Some centers had developed their own network and were ready for diversification and refinement of linkages. Other centers were unaccustomed to regular use of community resources to meet their needs, and thus the project promoted the concept via a few central resources to build up the center's acceptance and desire for community linkages in the future.

Over the third year of the project the staff utilized 65 different agencies for the planning and delivery of assessment and follow-through activities to the centers.

Interviews were conducted at the end of the third year with the project teams in which they responded to the checklist of 92 resources described earlier. The teams were asked to indicate which resources and services they had used on behalf of each center and home during the past twelve months. This was the same interview conducted with the directors, which will be discussed below. The project teams collectively reported utilizing 59 different agencies for 188 purposes (see Appendix E3). "Use" meant that a team had contacted a resource for at least one purpose on at least one occasion. The resources were roughly grouped according to primary service into health (42%), education (21%), human service (32%), and multiservice (5%) resources, and according to the type of service received. Health services were the most heavily utilized: nearly half of all resources contacted by the teams; the major proportion of these contacts were related to training activities, and training activities were the greatest overall reason for utilization of community resources by the project on behalf of the centers. Education resources were contacted most frequently in conjunction with program matters, such as materials, substitute caregivers, and actual program content. Human service organizations were utilized more heavily for training and administrative activities. Multiservice organizations were most heavily used in administrative matters.

The minutes from the third-year team meetings contained references to a total of 33 community resources, utilized by the project on behalf of centers and homes on 114 different occasions (see Appendix E4). Follow-through activities for the children and families in the centers accounted for more than two-fifths (41%) of the project's contacts with resources, and will be discussed separately below. Training activities were the focus of nearly another two-fifths of the project's utilization of resources, including gathering ideas and/or personnel for workshops and consultation (25% of contacts), and specific information collected for centers (12%). Smaller proportions of contacts were used to facilitate direct service delivery to centers by community resources (11%), and for information-gathering for the project's own needs. Health resources were used most frequently (36%), especially for follow-through needs of children, as were human service resources.

Overall, follow-through activities for children and preparation for training of caregivers were nearly equal foci for community resource contacts by the project staff. These contacts suggest approximately equal attention by the project to goals of increased skill in and recognition of the use of community resources on the part of centers; and the eventual transfer to community agencies of the screening and follow-through and thus training/consultation role the project performed for three years. Via project introductions to various resources, centers and homes were acquiring cumulative familiarity with various agencies that could meet their screening, follow-through, and training needs.

Over three years, a total of 29 different resources were used in the follow-through care of children in the day care centers and family day care homes in the project (see Appendices E5 and E6). This total did not include the numerous referrals to local doctors and dentists. In the first year six resources were used, for a total of 14 problems; in the second year 21 resources were utilized for the follow-through on 62 problems; 15 resources were used for the 32 problems in care for the third year. Different resources were used for one, two, or three years.

As more children were screened in the second year of the project, more problems were found requiring follow-through care in that year, and thus more community resources were necessary to attend to the children's needs (see Appendices E5 and E6). Health resources were used overall for about two-thirds of the referrals, and for proportionately more in the second year, due to the increase in the number of children who were health-screened that year. Human service organizations were, overall, one-quarter of the resources for problems, and education organizations about one-sixth. The proportion of health resources used was inflated by the specialized nature of health services, and thus the greater number of them available and utilized, whereas, for example, human service organizations could provide a range of services at one location. Relative to the maximum number of resources known to be available to the centers (92 listed, plus 4 added later on), 48% of all health resources were used, 20% of all education resources were used, and 19% of all human service resources were utilized. No multiservice organizations were contacted for follow-through activities.

The project utilized an increasing number of resources for a longer period of time as their own community resource network expanded (see Appendices E7 and E8). In the first year six resources were used by the project. In the second year, three of these resources continued to be utilized in the follow-through process, and 18 previously unharnessed resources were contacted to contribute to follow-through, reflecting both the large increase in number of children assessed and the project's increasing familiarity with the availability and willingness of community resources to cooperate in the follow-through enterprise. In the second year, one-third of known health resources were utilized.

Fewer children were assessed in the third year and hence fewer required follow-through. In this year the project re-contacted previously-obliging resources twice as often as they sought new resources, suggesting firmer links, by the third year, between the community resources, the project, and the day care center. These linkages may have been facilitated by the intra-agency organization taking place in the community. By the third year, the proportion of all education and human service organizations used had increased to approximately one-sixth of all available, while use of health resources had dropped to about one-sixth of all available.

Across the three years, just half of the health services used for one year were re-contacted for a second or third year, and three-quarters of the education and human services were re-contacted for a second or third year. As noted earlier, the nature of health resources is very specialized, so a wider range of highly specific resources was required for the more frequent health-related problems needing follow-through than for other types of problems.

Use of Community Resources by Center Directors

Directors of centers and family day caregivers were asked at the end of the third year to describe their use of community resources. This question was intended to determine the range and frequency of their contacts with community resources, as well as their reasons for contact and satisfaction with these resources, in order to arrive at a composite picture of centers' and homes' dealings with community resources.

The directors of eight day care centers and seven family day care homes collectively reported utilizing 65 different agencies in the community in the third year of the project, for a total of 234 purposes (see Appendix E9). "Use" meant that a director had contacted a service for at least one purpose, or on at least one occasion. The reported number of contacts with any one of the 65 agencies ranged from one (one contact by one director) to 22 contacts, the more frequently contacted agencies being those with a wider range of services.

The response from the directors' interviews in the first and third years were not directly comparable, as only three of the same directors were respondents for both the first and third years. One of these directors displayed an extensive knowledge and actual use of resources for the third year, and this, along with anecdotal evidence, seemed to indicate that the first-year interview responses were an understatement of that center's community resource utilization in the first year.

In the third year, directors and family day caregivers utilized two-thirds of the resources from the checklist for day care facilities and children in the county (see Appendix E10). Directors collectively used 58% of all health resources, 75% of all education resources, 71% of all human service resources, and every multiservice agency. Across these categories, one-third of all resources used were health-related, another third were human service agencies, one quarter were education facilities, and a small proportion were multiservice agencies.

Appendix E11 illustrates the frequencies of use over the twelve months of the third year by directors of community resources. "Standard" usage refers to resource services like fee payments, long-term treatment of a child, etc. "Heavy" use refers to contacts more frequent than once per month. The spread of frequencies between "standard" and "heavy" indicated that the directors had found resources to meet differing levels of demand.

Half of the references to contact with the five multiservice agencies were for heavy usage, indicating the centers' preference for the convenience of centralized multiservice agencies. In contrast, nearly half of the health agencies were contacted only one or two times, as though immediate service and closure characterized these interactions. The highly specialized nature of many health resources meant any one of them might be in low demand.

The reasons given by directors for utilization of community resources were recorded verbatim, and subsequently grouped into six need areas (see Appendix E9): (1) referral/treatment, (including evaluation follow-through); (2) information and consultation; (3) direct services to assist in the day-to-day functions of the center, such as materials, program assistance, and substitute caregivers; (4) administrative, financial, and other consultation with the director; (5) training activities (both informal and formal education programs, and information and consultation); and (6) assessment (health, hearing/vision, dental, and developmental).

Slightly more than two-thirds of the reasons given by directors and family day caregivers for individual resource contacts were equally distributed between referral and treatment needs of center children and their families, and direct services to the center. These two areas were both major foci for the project's attempts to increase the use of community resources by centers and homes. The project encouraged increased use in these areas by modeling resource use in assessment and follow-through processes, and by consultation, workshops, and the agenda of the directors' meetings. Training and assessment were less frequent reasons for directors and family day caregivers to contact resources, which was understandable in light of the provision of these services by the project to each center and home. Resources to meet families' needs were sought primarily from health and human service agencies, and the information and advice needed to attend to their needs were also sought primarily from health and human service resources. "Program" aids included materials, activities, and substitute caregivers; the major source of help in this area was from education resources. "Training" needs encompassed the collection of information for a center, informal demonstrations, and workshops; half of this help was sought from the multiservice agencies. "Assessment" was almost exclusively sought from the health resources. These represented a small proportion of the total number of resource contacts by directors and family day caregivers, but were a cornerstone in the project's model of community support of day care facilities.

The consumers of the resources were either the children, their families, the center, or a combination of these. Appendix E12 gives the relative proportions of utilization of each consumer group. The centers were their own primary focus (over one-third of their contacts) for reaching out to resources, especially the multiservice resources. These contacts were made for purposes like substitute caregivers, consultation with the director, and administrative advice. While the children in the centers were the clients for one-quarter of the services used, their parents and families received services for one-fifth of the total number of services used, demonstrating a significant level of commitment to the project's objective of increasing interaction with parents by centers. It was interesting to note that while children were catered to primarily by health resources, their parents and families were most often brought into the care of human service resources. In cases where there was more than one consumer ("multiple"), the use for children, their parents and families, and the centers, was approximately evenly spread.

Overall, the directors perceived that the consumers' needs were met, two-thirds "completely" and one-quarter "a fair amount" (see Appendix E13). A negligible proportion (5%) were evaluated as having been poorly cared for. Data from the follow-through on individual children indicated difficulties in obtaining complete attention to seven of the problems referred, so the directors' evaluation could have been inflated, perhaps reflecting their own satisfaction in having some level of service available for their centers' needs.

The characteristics of the services used heavily (see Appendix E14) have been examined as an indicator of what resources directors needed and found reliable enough to warrant return contacts. Multiservice agencies were used most, as already mentioned. The other salient feature of resources used heavily (to be discussed below for all resources used) was that they were primarily oriented toward administrative matters. This category of use accounted for over one-half of all use of agencies for advice in administrative areas. The "heavy use" category accounted for half of all usage of resources for consultation purposes related to children and families. The data show that staff and center were the major consumers of services that were heavily used. And those clients were very satisfied with the extent to which their needs were met, 84% saying their needs were met "completely." In the third year, it appeared the directors utilized at the highest frequency, resources relating to the day-to-day administrative functioning of the centers. This represented a balance to the project's program of assessment, referral, and training follow-through in the centers, as well as follow-up on the agenda of the directors' meetings. The directors seem to have been attending to their center's structure first, providing and maintaining a stable level of organization and service.

The project's role in the centers' efforts to utilize available resources was discussed with both the directors and the project teams. The directors indicated whether the project had facilitated or initiated each resource contact, or played no role at all. As a means for comparison, project staff had similar interviews dealing with each center in order to identify discrepancies in the reporting of the efforts by the directors and the project. Appendix E15 reports the roles accorded to, and by the project: the director's reported a lower proportion of contacts in which the project staff had aided than did the project teams. The project's "facilitative" role was perceived by the directors and by the project as occurring somewhat frequently, although only a minor percentage of the specific services seen as facilitated by the project were also perceived as having been facilitated by the directors. It would seem that what was "initiation" on the project's part was perceived by the directors as facilitation only, and much facilitative activity was not recognized as such by the directors. Several reasons may account for this. First, the project felt they were instrumental in facilitating many contacts via their resource lists, which were available and pointedly discussed with center directors and staff. However this was not seen as direct facilitation of contacts by directors. Second, later contacts and diversified use of an agency's services by a director may have obscured the aid of the project in establishing the initial contact. Perhaps also the directors perceived their role as more active than that of the project when they made the actual physical contact with an agency, even if they had been prepared for this contact by the project staff. The directors did see the project as providing the link to a resource more often in those needs areas in which the project actively promoted community resource contacts (see Appendix E16), namely referral, consultation, screening, and training. That is, the trends of perception were similar, although the absolute proportions were discrepant.

Directors indicated an overwhelming intention to maintain contact with the resources they had used in the third year (see Appendix E18), which attests to their satisfaction with the services received. When asked if there had ever been any services that they needed but could not locate, five directors said there were none. Three directors said thay had needed support services for parents, (services for school-aged parents who are drop-outs, a half-way house for school-aged parents, and ways to involve fathers in their program), temporary child care (crisis nursery, respite care for both normal and handicapped children, and foster care),and an on-call on-site ear and eye screening service.

The directors were asked to what extent, on a global level, the project had improved the type of contact they had with the resources they used (Appendix E18). The majority of the centers felt that the project had improved the type of contact they had had a fair or great amount. They generally felt that the project had made a contribution to their ability to use resources in the future.

As noted earlier, the initial sophistication level in using community resources varied from center to center, so the responses reported in the preceding paragraph are likely to represent rather different behaviors. One center, for example, already had considerable contacts with community resources, and, in fact, viewed the project itself as another of its many available resources. Other centers had had less initial experience with using community resources, and their project teams recommended that they use the local community's Child Care Coordinating and Referral Service as their primary link to other resources. In at least two centers, discussions at the final project/center meetings centered on ways they might use existing community resources to develop their own interdisciplinary teams.

Changes in Caregiver Skill Related to the Use of Community Resources

Skill in and recognition of the importance of the use of community resources on the part of the caregivers were two of the training goals of the project. A skill index for the caregivers' use of community resources was developed from the Caregiver Questionnaire using the mean of all community resource items across all ten topic areas. Similarly, the recognition by the caregivers of the importance of the use of community resources was measured by an index of related items from the Caregiver Questionnaire.

In the fall data collection, community resources was one of the two weakest skill areas, more than half of the caregivers rating themselves at a low level of skill on the items from this area (see Appendix D1). Changes in caregiver skills in the use of community resources from fall to summer of the third project year were measured using the Caregiver Questionnaire. Changes in the pre-post group's self-ratings of skill in using community rescurces from the pre-questionnaire to the post-questionnaire were positive and statistically significant (see Appendix D34).

Importance ratings in the pre-questionnaire results were consistently high across all topic and skill areas for caregivers (see Appendix D2), but the lowest ratings, relatively speaking, were for the use of community resources and record-keeping. This was consistent with the caregivers' lower skill ratings in these areas. So the caregivers did recognize the skill area of using community resources as important, but not as important as other skill areas. In the post-questionnaire, impcrtance ratings remained essentially the same for the pre-post comparison group (see Appendix D35).

CHAPTER 11: ASSESSING AND CONTINUING THE PROJECT MODEL

Assessing the Project Model

The evaluation plan originally included a plan to investigate the feasibility of defining a control or comparison group to compare with the project children on results of the health screen. However it soon became apparent that a truly comparable group did not exist. Because the project centers had been selected on the basis of their high proportion of DSS-supported children (and consequently a similarly high proportion of medicaid-eligible children), the available pool of non-project children eligible for medicaid and in day care would be small. A smaller group of these children would actually have been screened, and an even smaller group would have been screened more than once. This would produce a very small number of referrals to work with, precluding any stable estimates of proportions or their variances. Meanwhile, the project population and screening procedures were changing over the course of the three project years, further muddying the comparison group waters.

The alternative plan arrived at was to make use of the variations in project screening procedures (from on-site screening, to providing transportation to the health department, to leaving arrangements up to the parents) over the three project years, using county-wide data from the health department as a rough baseline. Changes in the numbers screened each year should provide evidence of the efficacy of the three procedures, at least in terms of actually getting children screened.

The numbers and approximate percentages screened each year are presented in Appendix B1. The "years" are project years; as actual points in time they are: spring, 1977; fall, 1977; and fall, 1978. Across the three time periods, the percentages receiving the health screen were 39%, 44%, and 16% from the first year to the third year. The comparable data* county-wide for 1976-1978, for all age groups (i.e., 0-21), were 36%, 31%, and 26% of those eligible receiving the health screen; the county-wide figures for 1974 and 1975 were 50% and 40%, respectively, indicating a fairly consistent downward trend in the proportions screened from 1974 to 1978.

For the project centers, the proportions of children receiving the health screen were fairly similar the first two years when the project played an active, organizing role for the screening--arranging for on-site screening the first year and setting up appointments and providing transportation the second year. The third year the project provided information to parents about how to make screening appointments but otherwise did not play an active role in arranging for health screens; the proportions of children screened in this year dropped considerably. Some of this decrease was caused by the failure of one center, new to the project the third year, to get the screening information packets to the parents in time; when this center is left out the figure moves up to about 19%. This figure is still low, however, particularly when compared to the figures for the DIAL (62%) and the dental screen (37%) for the third year, both of which were on-site and did not require parental presence.

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*Source: State Health Department EPSDT Annual Report, 1978.

The results of the three health screens in terms of types and seriousness of problems found are presented in Appendices B4-6. Comparable county-wide figures[7] for referral problems for all age groups appear in Appendix B10. The numbers for any one problem type are generally too small to make any real comparisons across years; overall, the percentage of children referred is fairly constant across all three years. County-wide there was a larger proportion of referrals, particularly for dental problems (based only on the health screen, not on the on-site dental screen); this may be due to the larger range of age groups for the county-wide data.

What may be of more interest is a comparison of the developmental and dental findings from the health screen with the results from the DIAL and the third-year on-site dental screen used by the project. The third-year EPSDT health screen of 59 children found 4 (6.8%) with dental problems, 3 of whom were already under care. The third-year onsite dental screen (a mobile van staffed by dentists, arranged for by the project) of 136 children found 53 (38.9%--see Appendix B7) with referrable problems--an even higher proportion than any of the county-wide, all age group figures. Only 11 children received both the health screen and the dental screen, and this did not include the four found by the health screen to need care; however, three children were found by the on-site dental screen to have moderate to serious decay who had nc dental problems indicated on the EPSDT health screen. The time span between the screens would have been, at most, three months.

The numbers, types, and percentages of problems found on the DIAL for each of the three project years are found in Appendix B3. While only a small number of the chldren down on the DIAL were actually referred (only 8 children), some form of follow-through planning was done for all children who were down on any DIAL criteria. With the typical EPSDT screening, only those children who have developmental delays serious enough to be referred are likely to receive care. For those children who received both the health screen and the DIAL (67 the first year, 122 the second year, and 28 the third year), the one child referred from the health screen and two of the three already under care were also down by DIAL criteria; the other child under care was down in fine motor and concepts. Of those getting both the health screen and the DIAL, 16.4% were down on some area of the DIAL the first year (8.7% down by DIAL criteria), 25.4% the second year (9.8% down by DIAL criteria), and 44.8% the third year[a] (10.3% down by DIAL criteria). This is not necessarily to say that the Denver Developmental Screening Test was not also picking up these problems, but if the problem was not serious enough for a referral, typically no other action was taken.

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[7] Source: Washtenaw County Health Department Annual Reports, 1976-1978. Breakdowns for 0-6 age group not available.

Appendix B19 indicates the project action for each problem found on the DIAL, based on the follow-through classifications defined in the section on the follow-through process. The bulk of the problems at all levels of seriousness were treated as nonreferrable, entailing consultation with caregivers and parents to determine a set of appropriate activities for the child or a decision to observe and retest the child later (observing and retesting did not preclude providing specified activities for the child). As mentioned earlier, the "referrable" problems which were not actually referred were typically lost to follow-through before they could be referred.

The final resolution of the DIAL problems (including referred, referrable, nonreferrable, and under care/extensive follow-through) are presented in Appendix B20; Appendix B21 shows the results for only those children down by DIAL criteria. As noted in the section on the follow-through process, for a number of nonreferrable problems the procedure was to provide initial consultation but not to make additional entries in project follow-through records unless continuing concerns were indicated. Thus, for a number of problems a resolution was not indicated, usually because there was no further cause for concern; in the case of DIAL problems, almost all of these were children down in only one of the three areas other than communications, (i.e., gross motor, fine motor, or concepts). Except for these areas in which the outcome is not directly known, a large proportion of the DIAL problems reached known resolutions--the problem was remediated, improving, or at least under care; this was particularly true for those children down by DIAL criteria.

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[a] In the third year, project staff encouraged caregivers to make a particular effort to get parental permission to DIAL any children they had specific concerns about, thus increasing the proportion of delays indicated by the DIAL relative to the first two years.

Summary

Along with the results for referred and nonreferrable problems discussed in the section on the follow-through process, the data discussed in this section point to some of the weaknesses in the traditional EPSDT screening program which an approach such as that taken by the project can help to ameliorate.

1) On-site screening in day care centers, or at least active efforts organized around day care centers to help parents get their children to screening sites, may be more effective ways of getting children screened.

2) An on-site dental screen, headed by a dentist, may be more effective than the traditional EPSDT procedure in identifying dental problems.

3) In the area of nonreferrable problems the project's approach allows for more potentially preventive activities than EPSDT is usually prepared to provide. Day care provides a vehicle, through training of caregivers and ongoing consultation with caregivers and parents, to help children with problems not yet serious enough for the more formal referral system.

4) In the area of referrable problems, the traditional EPSDT program sees itself as a source of entry into a health care system which provides continuity of care for the child; it is not in and of itself a provider of care. Once the initial referral appointment is kept, EPSDT's role is essentially over, with follow-through being up to the parents and the health care system (although in some cases a referral to a public health nurse accompanies a regular referral when it is expected the process will be lengthy). The approach developed by the project serves as a support system for continuity of care by working through day care centers with parents and the referral agencies to try to ensure follow-through on the sevices needed by the child.

Transfer to Local Community Agencies

A major project demonstration goal was the transfer of project responsibilities to community agencies, and there were definite efforts by resources to extend and coordinate services for day care centers. A questionnaire was developed for participants in the project's dissemination symposium in June 1979 (see Appendix E19). These participants were in essence a self-selected sample of people involved in the early childhood area who had shown enough interest to attend the symposium, and who, therefore, were likely to be receptive to the project's approach. Of the 48 respondents, 13, or 27%, were from Washtenaw County, and their responses provided the data for insight into the county resources' responses to the problems that were the project's concern. This group included no representatives of health service agencies. Of the 13 agencies represented, five were from education facilities, five from human service agencies, and three from multiservice organizations.

The first section of the symposium questionnaire was designed to determine the relevance of the project to the current activities of the respondent's agency and to provide information about "barriers" to the feasibility of the project. The thirteen respondents strongly confirmed the finding of the 1978 resource interviews that all the services that the project aimed to promote and introduce to the day care centers were available, some to the point of duplication of effort.

Over one-half of these agency representatives claimed to provide health and developmental screening, follow-through, and support services for children and families in a fashion similar to that of the project (this method had been described to the respondents during the symposium). Over one-third of the in-county agencies felt their services were highly similar to the project's activities. Two-thirds felt their level and type of interaction with other agencies and groups in the community corresponded "quite a bit" if not identically, to the project's efforts in this direction. These responses may reflect a similarity of concerns rather than an actual similarity of activities. In either case, they lend support to the project's ultimate goal of transfer of their activities to the local community resources. These same resource representatives did not feel they had gathered many new ideas about activities or approaches to screening, follow-through, and training services from the project's model. This would suggest either that many aspects of the project's model were embedded in the operation of the community resources, or that the resource representatives did not perceive any new approaches to their current delivery systems.

If an interagency program incorporating the project's approach were set up in the county, most of the representatives indicated that they could potentially play primary roles in providing the service delivery and back-up organization that the project had maintained, except for providing funds. Regarding primary roles: half the agencies felt they could actively provide direct services to day care centers and homes; nearly two-thirds could actively provide direct services to children and families; three-quarters felt able to play the less active role of responding to specific referrals from centers and/or other agencies; half felt they could play a potential coordinating role; and three-quarters felt they could function as a source of information for centers and/or families. The major identified obstacles to the project's approach centered around the input that was most basic to all resources: the availability of priorities for allocation of funds, time, and staff. Intra- and interagency dynamics, such as insufficient communication within and between agencies, or differences in agency operations and interests, were considered minor or negligible obstacles, although these had been identified as problems by some respondents to the 1978 agency representative interviews. So these representatives attributed to concrete administrative obstacles--funding, time, and staff--the crucial source of blame for any hindrances to their taking part in an interagency program that incorporated the approaches of the project.

At the same time, enthusiasm for and commitment to the project's model were expressed in the two questions regarding the feasibility and desirability of the project's approach--both overwhelmingly answered in the affirmative. Appendix E20 shows local agency representatives' evaluation of the desirability and feasibility of their community setting up a program based on the project's model.

Because these resource representatives were self-selected, having shown enough interest to attend the symposium, they were likely to be somewhat more receptive to the project's approach than other agency representatives might be. As the project was interested in disseminating an innovative approach, this was precisely the sort of group that was needed as a target for the early phase of dissemination--those people most likely to be willing to try the project approach.

Interagency Efforts

What evidence is there that the community might implement the project model, given the availability of all necessary services and the enthusiasm of some agency representatives for an interagency program incorporating the project's approach? Planning for such a program was instigated by several groups, at least three interagency groups meeting regularly during the third year of the project, to generate recommendations to resource directors and line staff regarding possible interagency dealings.

The primary group in this movement was the interagency consultation network of the Child Care Coordinating Referral Service, whose goals were "to enhance the quality, availability and delivery of consultation services to child care providers of children aged 0-5 (and) to develop a model of consultation coordination service delivery." This network of consultants met to provide a format for interagency and freelance consultants to meet; to receive support, peer consultation, and resources; and to facilitate collaboration and team development. Begun in September 1978, the network's committee published, in April 1979, an overview of the committee's progress and accomplishments, including both short- and long-term recommendations for increasing coordination of services among Washtenaw County agencies.

Following an assessment phase that focused on developing a common base of understanding and on identifying concerns, this network began a phase of building resources. During the process of meeting regularly around common issues, the group developed concrete resources and took steps toward supporting the network's communication and information-sharing intentions. Once the situation was assessed and they had begun to build the resource networks, the group was able to focus on expansion of resources and the communication system, and to identify organizational needs for further interagency involvement. Finally, recommendations for building programs in the community were developed.

The group's long-term recommendation was to increase coordination and communication through formal and informal systems. Enabling objectives included:

1) more interdisciplinary teamwork to support the image of the family as a whole, and to bridge the gaps in service delivery;

2) Exploration of confidentiality issues so that productive coordination could occur while confidentiality was honored;

3) Implementation of new interdisciplinary programs in the following areas: infant care, crisis care, after-school care, sick child care, intergenerational family support, and education;

4) Development of strategies that would meet needs generated by coordinated consultation and service;

5) Long-range budget planning to generate funds for consultation based on the needs of the community;

6) Recognition and use of child care centers as a base for interdisciplinary service delivery;

7) Recognition of needs for preventive-based programs in such areas as parent education, teen-aged parent support programs, early comprehensive identification programs including follow-through, systematic training for staff, and family planning.

The short-term recommendations focused on:

1) Continuation of interagency communication between agencies and workers serving families with children aged 0-5;

2) Expansion of the Child Care Coordinating and Referral Service (CCCRS) resources to meet the needs of service providers of children aged 0-5 and their families.

Examples of these recommendations that have been developed and actualized since this report was distributed include a presentation of the network concept during CCCRS training sessions for day care providers, and the development of a parent handbook and a consultation packet.

Summary

By the end of the project, there was evidence that community agencies were attempting to work through many of the same issues addressed by the project and that, as indicated in an earlier chapter, day care centers were reaching out to community agencies for the kinds of services provided by the project. The recommendations listed above from the interagency committee reflect many project concerns, and some reflect the direct or indirect influence of the project on the committee. In either case, they represent an interest in and commitment to an interdisciplinary approach to services for families and child care centers. In addition, the project has trained a core of community service workers in the use of the DIAL and has made its training modules available to the CCCRS. Thus, while it is too early to assess the full extent to which the project's approach may be adopted and adapted by the local community, the groundwork has been laid for the incorporation of project ideas into community service delivery.

CHAPTER 12: SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Introduction

The City/University EPSDT Day Care Project has accomplished its major goal. It has demonstrated the use and benefits of coordinated, interdisciplinary teams to provide outreach, assessment of the "whole child's" health, follow-up, case monitoring, and technical assistance to caregivers. In so doing, it has demonstrated that a meaningful comprehensive child health assessment program can be implemented through day care. With the assistance of community practitioners, caregivers have been better able to address the special needs of children during the crucial developmental period from birth to five years, and have better met the needs of these children's families. The Day Care Project field-tested a program of day care support for continuity of comprehensive health care, a model which may be useful in future policy planning on a local, state, or federal basis. In addition, the model has demonstrated the practical value of enhancing linkage between day care and the wide variety of available community resources.

In this report, comprehensive is used in two senses. First, it is used in a linear sense to mean outreach, assessment, and follow-up, which includes case monitoring and long-term follow-through. Second, it is used in a more global sense to refer to a "whole-child" philosophy of health: health is seen as an interdependent relationship among physical, cognitive, social, emotional, and environmental aspects of the child's development.

Since the system developed by the project for comprehensive child health assessment through day care is consistent with the kind of assessment recommended in Developmental Review as expressed in the 1977 Final Report prepared by the American Association of Psychiatric Services for Children, we will also use two of their terms: assessment, to describe the process of our comprehensive health methods, and screening, to describe the medical assessment stage of our review of children's health.

The project's initial concern with health and with enhanced EPSDT services led us to explore broadening the health services available to young children and their families. In considering goals for a wider range of services, the project worked from three assumptions: first, that most health problems could be corrected or eased by providing children with broader health services; second, that children's health is an interrelation among physical, developmental, social-emotional, and environmental elements; and third, that if the project improved the overall health of children, both human stress and money spent on health care would be reduced in the long run.

Based on our assumptions and on our evaluation of services available, the project developed three major goals for improved health services: to provide clearly defined comprehensive health assessment for children; to expand health services available to the children assessed; and to link service providers so they could coordinate their assessment and follow-up procedures to reduce fragmentation and duplication in service delivery.

The project saw day care as a viable means of reaching these goals. In three years, a population of approximately 750 children and their families were served through day care centers and family day care homes in Washtenaw County. We developed methods to expand the role of day caregivers so they could provide for comprehensive health assessments for children in their care. We also provided services and training so caregivers could adequately follow up assessments with any needed services. This method demonstrated its benefits: it ensured that children received follow-up for problems identified during assessment and health care attention for problems which arose between assessments. It also provided a channel for coordinated outreach by community resources which allowed them to increase their preventive services for young children with little increase in cost. The approach also allowed agencies to return to a secondary support role for families, giving the primary support role to day caregivers--the people closest to the family in its daily activities.

Procedures and Instruments

Interdisciplinary Methods

The project developed teams composed of a nurse, a social worker, and an early childhood education practitioner. Each team of three specialists was aided by a team assistant who recorded and distributed team minutes, kept files up to date, did groundwork and research where necessary, and gave general assistance in assessing and preparing training activities. "Interdisciplinary" has several meanings, and the interdisciplinary element in the project's approach has evolved through several of them. The project began with separate disciplines working along side one another--something of a multidisciplinary approach. By the third year, the staff had been reorganized along more interdisciplinary lines.

The three team members worked together to integrate their areas of individual expertise. Each team member served as a generalist, not in the sense of an individual operating across disciplines, but rather as a specialist who could also take into account the resources and frames of reference of other disciplines. Each individual team member carried out training and follow-through activities, including contacts with community agencies, in her own discipline, and each team worked together so that all disciplines were represented in the content of workshops and in the follow-through decisions made.

This interdisciplinary approach was essential in two major project thrusts: programming and coordination. Programming dealt with the immediate delivery of day care services to the child and his or her family. In coordination efforts the child's relation to his or her whole environment (home/center/community) was of concern. Interdisciplinary programming in this area allowed us to, for example, have an increased awareness of the relationship of physical problems to social-emotional behavior concerns, and to have integrated skills and resources immediately available to remediate problem situations.

The second major use of the interdisciplinary approach was in interagency coordination. It allowed us to deliver services with qualitative efficiency and to effectively utilize the specialized skills of providers from various agencies.

The physical proximity of the interdisciplinary team members, being housed together in the same office, probably had a considerable effect on the coordination of the disciplines. Informal, everday contacts reinforced the team's more formal meetings and increased communication. It is less likely that this sort of proximity would be immediately available to community agencies adopting the project's approach, but its effect should be kept in mind, and similar or alternative means of increasing interdisciplinary communication should be considered.

Project Activities

Project activities can be broken into two major phases. Each of these phases can be further broken down into the stages in which the project's interdisciplinary methods and instruments were implemented. The conceptual framework for the project's goals and procedures are diagrammed in Figure 1.

Phase I: The Comprehensive Health Assessment Process (see Figure 2):

Stage 1: Parents fill out the Health and Developmental History Intake Form and discuss it with a day care staff person. The form is one developed by the project and adapted by each center to meet its needs (Appendix A3).

Stage 2: Medical screening is provided for the children. (For optimal and efficient participation, the project recommends this be done on-site.) This includes the EPSDT protocol and dental screening (or a modified screen in accordance with particular needs of a specific community).

Stage 3: A comprehensive developmental assessment is administered on-site by day care staff and practitioners working together, for each child whose parent has given permission. The Developmental Indicators for the Assessment of Learning (DIAL) was the assessment instrument used in this stage.

Stage 4: Feedback sessions are held between day care staff and project staff to integrate the information obtained from the health assessment process and from observations. Remediation plans are made for groups of children and for individual children for whom there is concern.

Stage 5: Follow-up takes the form of communication with parents, individual referral, monitoring of referrals, training, consultation, health and safety policies, and records (see model Health Policy in Health Training Modules).

Phase II: Technical Assistance--Consultation and Training (see Figure 3):

Stage 1: The comprehensive health assessment process of Phase I continues. There is continued observation for children with special needs; the intake form is provided to newly enrolling parents; there is continued monitoring of referrals and program plans; health and developmental assessments continue to be available.

Stage 2: The Caregiver Questionnaire is provided to caregivers, directors, and practitioners to assess needs for training and consultation. The questionnaire is a comprehensive instrument developed by the project's interdisciplinary staff with the assistance of the evaluation team. (See Figure 4 for the conceptualization of the needs assessment.)

Stage 3: Mutual goal-setting sessions are held between project staff members and day care staffs during which information from the health assessments, the caregiver questionnaire, project staff observations, and caregiver ideas about their training needs are integrated. Goals are agreed upon and training and consultation plans are made for implementing the goals. Goal-setting sessions can be held periodically to reassess previously set goals and accomplishments, and to reset goals when necessary.

Stage 4: Interdisciplinary consultation and training sessions are provided at central locations for basic and common topics, and on-site at day care centers or in day care homes to meet individual goals. (Training materials developed by the project are in the modules on health, social-emotional needs, and curriculum.)

Stage 5: Continuous observation and follow-up for individual children for whom there is concern and consultation with day care staff provide follow-through and implementation of plans for children and day care staff. This is an ongoing means of case management support for day care staff.

Summary of Activities and Findings

Medical and Dental Screenings

Different approaches to providing medical screening were taken each of the three project years. The first-year screening was done on-site. The second-year screening was provided at the health department's county service center, with the project providing transportation. In the third year, families provided their own transportation to the county service center where screening was held. The proportions of children screened were approximately the same the first two years (39% and 44%), while in the third year the proportion dropped considerably (16%). This drop reflected the inconvenience of the time when screenings could be scheduled (during parents' working hours) and the difficulty of getting to the county service center for screening. Also, there were many children who had been screened the previous year whose parents did not choose to participate a second time, and there was one new center the third year which did not participate in the screening program at all.

In the third year an on-site dental screening was also arranged by the project. Thirty-seven percent of the children in the project received this screening.

The number of children who were found in the medical screening to have referrable problems was lower than in the general EPSDT population, age 0 to 5, perhaps because the project served more middle class children than the normal EPSDT population. In 1978 in the U. S., 55% of the children aged 0 to 5 given the medical screening had referrable conditions. In Washtenaw County, 33% of the children screened in this year had referrable problems. The project, during its three years of screening, found, respectively,

FIGURE 1: CONCEPTUAL FRAMEWORK FOR INTERVENTION STRATEGY

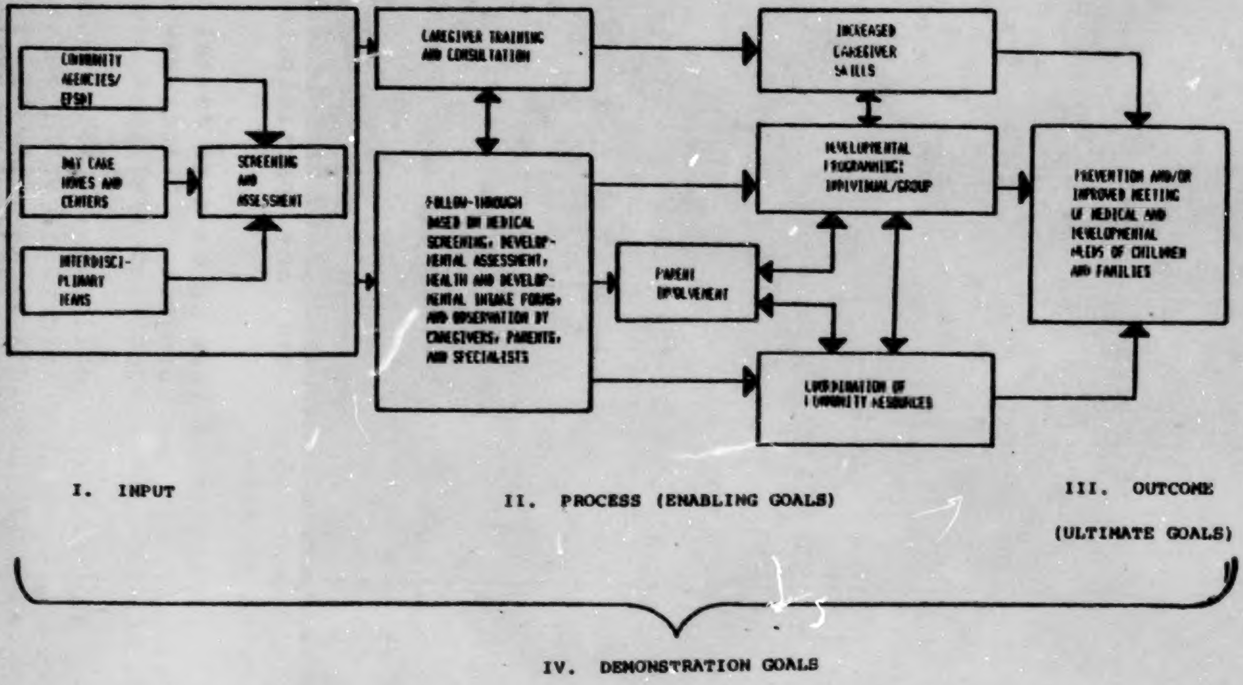
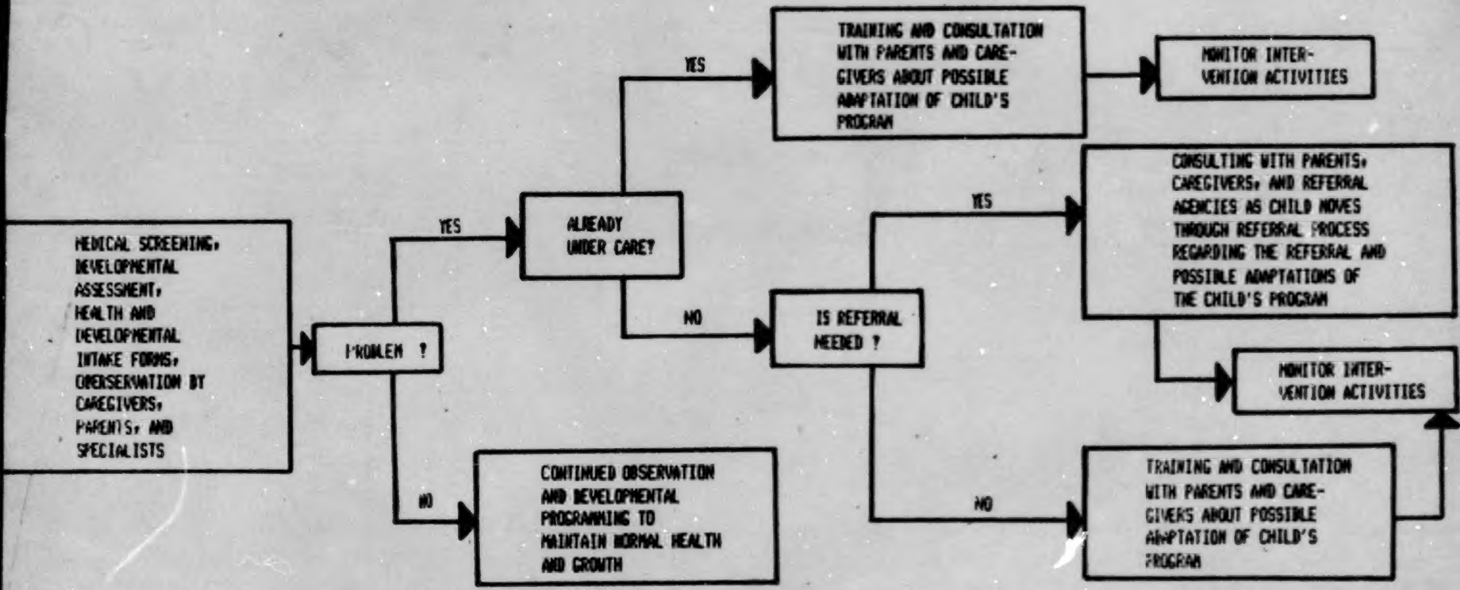

COMMUNITY AGENCIES/ EPSDT
DAY CARE HOMES AND CENTERS
INTERDISCIPLINARY TEAMS
SCREENING AND ASSESSMENT
CAREGIVER TRAINING AND CONSULTATION
FOLLOW-THROUGH BASED ON MEDICAL SCREENING, DEVELOPMENTAL ASSESSMENT, HEALTH AND DEVELOPMENTAL INTAKE FORMS, AND OBSERVATION BY CAREGIVERS, PARENTS, AND SPECIALISTS
PARENT INVOLVEMENT
INCREASED CAREGIVER SKILLS
DEVELOPMENTAL PROGRAMMING: INDIVIDUAL/GROUP
COORDINATION OF COMMUNITY RESOURCES
PREVENTION AND/OR IMPROVED MEETING OF MEDICAL AND DEVELOPMENTAL NEEDS OF CHILDREN AND FAMILIES
I. INPUT
II. PROCESS (ENABLING GOALS)
III. OUTCOME (ULTIMATE GOALS)
IV. DEMONSTRATION GOALS

FIGURE 2: FOLLOW-THROUGH PROCEDURE


MEDICAL SCREENING, DEVELOPMENTAL ASSESSMENT, HEALTH AND DEVELOPMENTAL INTAKE FORMS, OBERSERVATION BY CAREGIVERS, PARENTS, AND SPECIALISTS
PROBLEM ?
YES
ALREADY UNDER CARE?
YES
TRAINING AND CONSULTATION WITH PARENTS AND CARE-GIVERS ABOUT POSSIBLE ADAPTATION OF CHILD'S PROGRAM
MONITOR INTER-VENTION ACTIVITIES
NO
IS REFERRAL NEEDED ?
YES
CONSULTING WITH PARENTS, CAREGIVERS, AND REFERRAL AGENCIES AS CHILD MOVES THROUGH REFERRAL PROCESS REGARDING THE REFERRAL AND POSSIBLE ADAPTATIONS OF THE CHILD'S PROGRAM
MONITOR INTER-VENTION ACTIVITIES
NO
TRAINING AND CONSULTATION WITH PARENTS AND CARE-GIVERS ABOUT POSSIBLE ADAPTATION OF CHILD'S PROGRAM
NO
CONTINUED OBSERVATION AND DEVELOPMENTAL PROGRAMMING TO MAINTAIN NORMAL HEALTH AND GROWTH

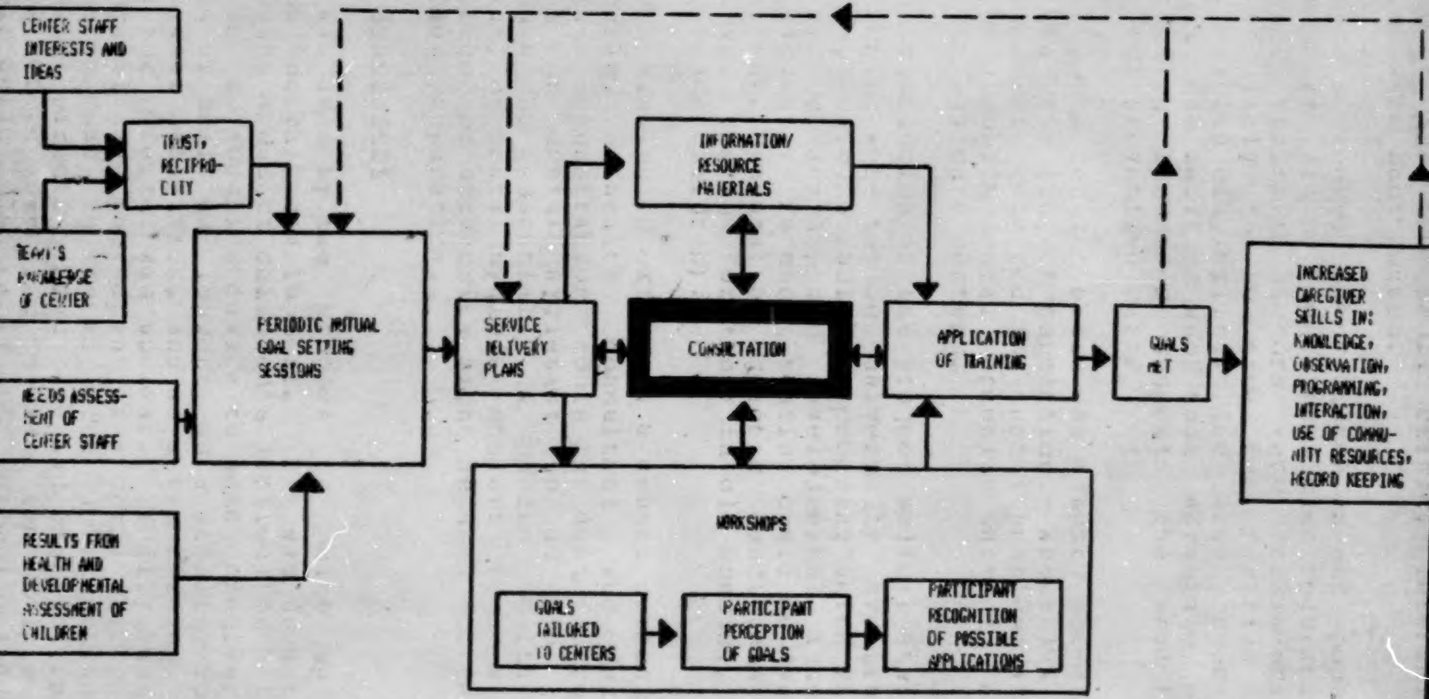


FIGURE 3: CAREGIVER TRAINING AND CONSULTATION

CENTER STAFF INTERESTS AND IDEAS
TRUST, RECIPROCITY
TEAM'S KNOWLEDGE OF CENTER
PERIODIC MUTUAL GOAL SETTING SESSIONS
NEEDS ASSESSMENT OF CENTER STAFF
RESULTS FROM HEALTH AND DEVELOPMENTAL ASSESSMENT OF CHILDREN
SERVICE DELIVERY PLANS
INFORMATION/ RESOURCE MATERIALS
CONSULTATION
APPLICATION OF TRAINING
GOALS MET
INCREASED CAREGIVER SKILLS IN: KNOWLEDGE, OBSERVATION, PROGRAMMING, INTERACTION, USE OF COMMUNITY RESOURCES, RECORD KEEPING
WORKSHOPS
GOALS TAILORED TO CENTERS
PARTICIPANT PERCEPTION OF GOALS
PARTICIPANT RECOGNITION OF POSSIBLE APPLICATIONS

FIGURE 4: ITEM CONTENT MATRIX FOR CAREGIVER QUESTIONNAIRE/CENTER NEEDS ASSESSMENT

TOPICS FOR CAREGIVER TRAINING

DEVELOPMENTAL SKILLS

HEALTH
SAFETY
NUTRITION
GROSS MOTOR
FINE MOTOR
CONCEPTS
COMMUNICATION
SOCIAL/EMOTIONAL DEVELOPMENT
PARENT INVOLVEMENT
STAFF INTERACTION

1. KNOWLEDGE	(Basic information needed prior to application)
2. OBSERVATION	(Recognizing, detecting, assessing, diagnosing specific behaviors or problems)
3. PROGRAM PLANNING	(Matching activities to abilities, using materials appropriately, organizing ideas for program implementation)
4. INTERACTION	(Building rapport or relationship, modeling, managing, presenting, implementing planned activities)
5. USE OF COMMUNITY RESOURCES	(Finding resources appropriate to needs, facilitating family contacts with community agencies)
6. RECORD KEEPING	(Developing and/or maintaining a record-keeping system to chart progress or changes, using records in planning)

20%, 25%, and 19% of the children screened to have referrable problems. For the combined referrals made by the health department and the EPSDT clinic, referrals for hearing problems were most common.

Project records showed that children in our population for the most part did not see a physician regularly on a preventive basis. Visits to doctors were crisis-oriented. This was most likely to be true for families on the borderline of medicaid eligibility. The large proportion of non-medicaid eligible families who took advantage of the project's screening resources suggests the need felt by these families for preventive care.

Dental care on a regular basis was almost non-existent for children in the project population. About 39% of the children screened were referred for dental problems after we had arranged for a mobile dental screening unit to examine children at their day care centers.

It is the conclusion of the project medical staff that if medical screening were to be universally available to children in day care, a modified screening which included only hearing, vision, dental, and developmental assessment might be sufficient. Further testing could be available when particular environmental or genetic conditions exist (e.g., lead-level testing for those in old housing, sickle cell tests for black children).

For centers wishing to extablish a dental screening and follow-up program, a health consultant who provides information and demonstration tools for dental screening, and a dentist or dental hygienist to do the actual screening, would be essential. A public health nurse, dental assistant, or dental hygiene student from a local community college or university might be used for teaching and dental screen preparation.

Developmental Assessment

The DIAL was used by the project to point up gross deviation from normal development. It was used to help observers pinpoint areas of children's difficulty. It was also useful as a teaching device to make caregivers more aware of stages of child development, as a planning tool for group developmental activities, and as a rescreening device where the need for referral was unclear. Finally, using the DIAL in preschool gave the parent of a child with problems additional time to come to terms with a troubling life situation. Many parents needed time and notification from several sources before accepting the fact that help might be needed for their child. The early DIAL screening aided this process.

Developmental screening for the day care population in Washtenaw County may be continued by the 4C's organization, Child Care Coordinating and Referral Service, following project termination. This agency is setting up a Consultation Referral Service with consultants from community agencies who have been trained by project staff to administer the DIAL. They, in turn, will train caregivers from interested centers to give the DIAL under their supervision. If necessary, DIAL administration can be limited to those children about whose development the parent or caregivers have a question, thus reducing the screened population to a size that is manageable and one which could be followed up by caregivers and a small group of consultants.

Problems in Referral

When the project first approached screening, a major goal was to locate handicapped preschoolers and to make certain they received adequate diagnostic testing and subsequent treatment as provided by the Federal 9401 legislation and PA 196. Actually the project uncovered few such children, and most of those we found had already been identified. However, the project followed these children to make certain they received the services to which they were entitled, and in the process became aware of certain shortcomings in the agencies serving the preschool handicapped. Often the agencies were guilty of non-compliance with the law which requires action within 39 school days of referral. Except in extreme cases, the school systems did not provide and were unwilling to pay a day care center for consultation about rehabilitative services. (Some consultants were sent to the centers to provide or advise on programs for speech problems.)

Although the project located few handicapped children, by working with the caregivers we uncovered a number of minor developmental problems. For example, children with slow speech or language, or other inadequate communication skills, which would not qualify them for services under the handicapped law, were found. Left untreated, by age six or seven they might become special needs children. Caregivers needed help with these children, help which the project's interdisciplinary team of consultants could usually provide. Unfortunately, when the project terminated no public agency assumed this responsibility.

Case-management

For the handicapped child and for the child with minor problems, the project's interdisciplinary teams played the role of case manager. The teams followed the child through screenings, diagnosis, if indicated, and subsequent treatment. They helped the staff plan programs and observed the child's progress. They also helped staff reach parents, many of whom were reluctant to face the possibility of their child having problems. At the end of the project, the director of a day care center might become the case manager if she or he had supportive consultation. This would be especially important where she was dealing with a denying or abusing parent. With this support, the director would be in a good position to take case-management action and follow it through. Partly as a result of the project's activities, local community agencies have begun to look at day care facilities as a real resource, and centers have more knowledge of community agencies, thus further easing the director's potential role as case manager.

Record-keeping

Project findings paralleled those of the 1974 Ann Arbor City Day Care Study on the state of day care center records. Records, and especially health records, were scattered, in poor condition, and not easily available. To counteract this problem, the project provided every center with a health policy prototype which outlined necessary health records. Something similar to this will soon be required by the state. (This prototype is available in the Health Modules of the training materials.) Currently all of the project centers have improved their record-keeping systems and many have adopted the project intake form which combines medical and developmental information.

Health and Safety

Health and safety was a topic on which the project succeeded considerably in raising consciousness. Some caregivers said this was the best contribution of the project. Changes in this area were often basic, often simple. Several centers were helped to put first aid kits together for the first time. In one center, the sheet for listing administration of children's medications was far from the refrigerator where the drugs were usually administered, so signing was erratic. A project suggestion to move the sheet was adopted and greatly improved the record-keeping.

Project nurses were quickly available for medical crises, like lice or a child stuffing something up her nose. The project staff responded and left behind some written factual material so that a reasonable medical protocol would be available for the next similar crisis. Each center was also given a ring binder of cards that pictured and described the symptoms and treatment of common illness or infestation. Finally, since a recent audit by DHEW showed many Michigan centers to have health and safety violations, the project developed safety check lists for each season to facilitate proper safety measures (available in the Health Training Modules).

Parent Involvement

From its inception, the project objectives stressed parental involvement, and efforts were made to involve parents in all phases of project activity. The project required parents' knowledge and permission for all procedures involving their children. Information about the results of all screenings were sent, or given directly, to parents. In addition, parent involvement was both a hidden and an open agenda item in the project's training effort. In all of our training and consultation we stressed the importance of eliciting all information about a child from his or her parents and the necessity of planning and problem-solving with parents. Parent involvement was an explicit goal for all of the centers involved in goal-setting; it was also an implicit goal in most, if not all, of the training in the other goal areas.

While several centers made significant changes in working with parents based on project recommendations, for the most part project staff felt there was little real movement toward increased parental involvement in most of the centers. The fact that all centers adopted parent involvement as a goal indicates some recognition of the need for increased parent involvement (project staff lobbied for the goal prior to mutual goal-setting, however), and all centers, of course, already had some form of regular contacts with parents. Unfortunately, like any of the interpersonal relations areas, parent involvement was an elusive training area and a difficult one in which to put specific program activities into effect. Because of the difficulties both in training and in measuring change in this area, for many of the centers parent involvement goals were only partially met.

One important project product was aimed at Parents. This is the Parent Activity booklet, Big Hands, Little Hands Together. It was sent out to each parent along with the results of the developmental assessment. The booklet gives many examples of specific children's activities that foster development in the four areas of the DIAL--gross motor, fine motor, concepts, and communication--and that can go on at home.

Training and Consultation

The technical assistance phase of the project included both immediate and long-term follow-through and prevention activities. Follow-through activities ensured long-term case monitoring for children with special needs as identified by the formal health, developmental, or dental assessments, or by more informal observations by parents, caregivers, or project staff. Case monitoring was done primarily through ongoing consultation on children who had referrable and nonreferrable medical or developmental problems. Prevention activities included increasing caregiver knowledge and skills in observation; programming, including record-keeping; working with parents, possibly preventing problems for all children in a family; and training for caregivers in child development. This last was particularly important because the more caregivers knew about development, the better able they were to plan appropriate activities and to know when children had problems in development.

Among the most salient aspects of the project's follow-through approach was its capacity to deal with problems which had not reached the referral stage. Project teams were able to alert centers to the implications of conditions indicated on the Health and Developmental Intake Forms which might affect children's behavior or welfare while in the center. Further, they were able to provide information to the centers about program adjustments or support for children with problems already under care. Because the project was interdisciplinary, the team could assess problems from a variety of angles--the developmental and social/emotional implications of a hearing problem, for example.

Caregivers played an important role in prevention. Since they could observe children on a day-to-day basis, they could provide information useful for interpreting the validity of the results of the developmental assessments. The project teams worked with center staffs to provide supportive, preventive programs, both in the short run for specific children with identified problems, and in the long run by providing training for staff members. The on-site accessibility of the project teams also allowed them to respond to a number of informal requests from caregivers or parents for preventive consultation or information.

The project's follow-through efforts were important when referrable problems were discovered. The project teams followed most referred problems beyond the initial appointment, which is in most cases the stopping point for the traditional EPSDT follow-up process. For intensive follow-through efforts, the teams were able to provide continuity by following the remediation process as it moved among several community service agencies. The value of the project's follow-through approach may be most apparent for developmental problems, where problem identification typically is not clear-cut and where services are often difficult to obtain. Working with caregivers and parents, the teams helped to build preventive center programs for low-level problems, and, where referrals were needed, they were able to help parents and children obtain the services necessary.

The table in Appendix D6 provides a thorough review of the technical assistance offered by the project to increase caregiver skills in prevention and follow-through on behalf of the young children in their care. In the process of providing this technical assistance, the project developed a number of useful methods and instruments, and these are described below.

Establishing Relationships with Centers:

The foundation for consultation and training was the relationship between the project and the center staff. It was the critical factor in determining a center's willingness to utilize the information and approaches the project offered.

There were several ways in which this relationship was fostered. The first was the use of a project team coordinator or liason to each center. This person attempted to establish herself almost as part of the center by visiting frequently and often working with the children. She could provide a model for desired behavior and lessen the distance to herself as "the professional." Once trusted, she could establish the credibility of the rest of the team.

The project's attitude toward the center was also critical in forming a good relationship, and was based on a non-judgemental attitude of respect, particularly toward the center's autonomy, style, knowledge base, and philosophy. A formal agreement preceded any work with a center. Project staff also tried to be sensitive to the concerns of the center--responding to needs when the center staff themselves recognized those needs and were ready to work on them. Ideally, the project tried to maintain the authoritativeness and perspective of an outsider combined with an insider's understanding of the individual setting.

Final aids to relationship building were the on-site visits of the project team. First it was necessary for each team to start the process of building internal trust and consensus. Then the entire team went to the center to administer the DIAL and later to give feedback on it. All were usually present at the on-site workshops. This provided a good opportunity for project and center staff to become acquainted and to develop the reciprocal, open, working relationships necessary for concentrated training and consultation activities.

Needs Assessment and the Caregiver Questionnaire:

In the first and second year several approaches were tried, but it was not until the third year that the project teams were able to develop a comfortable and productive way to assess a center's training needs. The teams did not want just to observe and pass judgement on a center, but rather wanted to find a systematic way for centers to have input into an assessment of their needs. Consequently the Caregiver Questionnaire (Appendix A2) was developed. The questionnaire had two advantages: it provided a systematic means for center staff to assess their own needs, and, in the process, served as a self-educating tool. The topical headings in the questionnaire were Health, Safety, Nutrition, Gross Motor, Fine Motor, Concepts, Communication, Social-emotional, Parent Involvement, and Staff Interaction.

The questionnaire was completed by each caregiver, and a slightly modified version of the same questionnaire was filled out by the center's director and by the project team. When all questionnaires for each center were compiled they provided a profile of assessed needs for that center.

Mutual Goal-setting:

Once the screening phase of activities was completed and the Caregiver Questionnaire was filled out, the project needed a way to transform this information into goals for effective and individualized consultation and training for each day care setting. Again, it was in the third year that these mutual goal-setting sessions were systematized.

Mutual goal-setting sessions used information from the DIAL group profiles (Appendix A12), relevant health screening results, the center's needs assessment profile put together from the questionnaires, team and center staff observations, and center priorities. This information, along with the center staff's current ideas, was synthesized, and from it goals and priorities for the next six months of consultation and training activities were determined.

The great variation in the goals set by the different centers speaks to the flexibility and responsiveness the team maintained during goal-setting and follow-up. The result was a highly individualized approach to training and consultation.

Workshops:

By the third year of project activities, training methods were developed that were responsive to individual center's needs. The project approach encouraged more center initiation in training, more mutuality in defining and achieving goals, and more informal consultation than had been possible in previous years.

The project used both individualized, on-site training on topics generated by the mutual goal-setting sessions, and central, "core knowledge" workshops. These proved to be highly effective both in training new day care staff in fundamentals and in meeting the specific needs of each center. In total, the project provided fifty-three workshops on twenty-eight different topics during the third year. During the project's three years of training activities, centers asked that training move from an initial concentration on the major curriculum areas of the DIAL to more emphasis on social-emotional and health and safety issues.

In general, the project's workshops were developed to take into account participants' interests and needs; the logistics of time, available space, and group size; continuity between workshops; and ways to encourage maximum participation. The workshop format was generally a formal presentation with time for questions, combined with participatory and experiential methods like caregiver participation in activities for children; problem-solving; role-playing; "make-it-and-take-it"; and support techniques such as films, displays, and hand-outs.

Consultation:

The project found that for greatest impact, the consultant had to vary her role to meet the demands of the situation encountered. Project staff used a continuum of consultant roles, from least to most directive, as described by Gordon and Ronald Lippet in, The Consulting Process in Action. These roles consist of: the objective observer/reflector; process counselor; fact finder; joint problem solver; trainer/educator; information specialist; and advocate.

The project offered consultation to serve six major functions. A great deal of consultation occurred as follow-up to developmental assessment. Teams met with center staff, parents, and personnel from other agencies to discuss results and to recommend action. Health consultation included follow-up of the "Common Illnesses" workshops and of health screening. This was most often referral to an eye doctor or an orthopedist, but other consultation was done. Consultation in social-emotional areas was woven into almost all discussions concerning children. Often the team dealt with concerns about aggression, separation, withdrawal, and toileting. Many project consultations occurred around curriculum and program planning with both directors and staff members. This included aiding centers in the orientation and training of new and inexperienced staff.

Parent involvement was yet another area for consultation. Centers seemed to have no one definition of parent involvement, and consultation involved anything from informing centers about a special parent-interview video tape being done by the Child Care Coordinating and Referral Service, to providing suggestions and materials for a Make-It-and-Take-It workshop organized for parents by the center. With every opportunity, project staff tried to promote a better understanding and a closer working relationship between center staff and parents.

A final area of consultation was in staff relations. One center requested special assistance with staff communication skills, and the topic was the focus of several workshops held for center directors.

Follow-up for Technical Assistance:

A lot of information was delivered in a short time during project workshops. To enhance the effect and relevance of the material presented, it was important to reinforce it after the workshop was over. This was done through various hand-outs; carrying through with requests for follow-up expressed by caregivers on their workshop evaluation forms; giving encouragement to reinforce any changes made in response to a workshop; and providing consultation to meet requests which arose at the workshops.

Group meetings with center directors were also held to explore ways to reinforce and follow-through on screening, consultation, and training activities with their staffs. The meetings provided support for the directors and reinforced the training and consultation occurring in their centers. The sessions also increased the directors' use of consultation resources from the project and from the community to help them meet their roles and responsibilities.

The project determined, after the third year, that holding periodic mutual goal-setting sessions would further improve the project model. More frequent sessions would allow day care staff to reassess, clarify, and amend their goals as the year progressed.

The technical assistance provided by the project resulted in the development of training materials which have been published to share the content of workshops and to suggest methods for utilizing them. The materials consist of a series of three books: "Teacher, I Don't Feel Well:" Meeting Children's Health Needs, which includes modules in the areas of First Aid and Common Childhood Illnesses, as well as a model health policy for day care centers; "Feeling Good:" Helping Children Grow Emotionally and Socially; and

"What Do We Do Today?": Planning a Developmental Curriculum.

The training materials are designed to be presented in workshop format, by trainers, to an audience of caregivers of young children. The materials are also appropriate for self-instruction, Child Development Associate Training, and courses at the high school, junior college, or university level.

Each workshop module includes everything a trainer needs to present the program: training objectives, factual material, suggestions for presenting the material, resource articles, follow-up ideas and hand-outs which may be reproduced for participants. Pages designed for and used by the project as handouts are marked with the project title.

It is recommended that these training materials be used within the context of mutual goal-setting, ongoing availability of consultation for follow-through support, and evaluation of the effectiveness of the technical assistance by the methods identified below.

Evaluation for Technical Assistance:

The project had three methods for evaluating workshops and consultations:

1) Evaluation forms were filled out by caregivers after each workshop to assess the extent to which specific workshop objectives were met (Appendix A15);

2) Following training sessions, project staff conducted their own self-evaluation, which incorporated caregivers' comments from the evaluation forms;

3) The project periodically assessed the overall goal-attainment of each center which resulted from consultation and training activities, and it assessed the value of its longer-term assumptions about the interrelationship of health assessment, consultation, and training, the value of the interdisciplinary approach, and the impact of increased caregiver skills on prevention.

The time needed to validate the effect of training on permanent change and growth of skills was greater than the duration of the project allowed. However, small but consistent gains were measurable. Linkages were found between needs assessment, goal-setting, training delivery, and training application, which indicate that progress toward center goals was indeed made.

Changes in the pre-post caregiver group skill self-rating were consistently positive, although in only a few areas statistically significant. The most positive changes were in the health and safety areas and in the use of community resources across all the areas.

Evaluation also indicated that where consultation was used to facilitate and reinforce the application of training, the effectiveness of the training was likely to be greater. Thus, consultation played a central role in facilitating the application of training and in the meeting of goals. As ideas were used and goal attainment was assessed, the information was recycled back to mutual goal-setting and/or service delivery planning. This recycling was particularly important given the high staff turnover rates in day care--needs had to be continuously reassessed as new staff moved in.

Family Day Care

As with day care centers, the extent to which project goals could be met with family day care (FDC) depended on the relationship, trust, and rapport between the FDC consultant and the FDC-giver. But the nature of the FDC setting altered the ease with which this relationship could be forged. The FDC center is smaller, home-based, and more isolated from the flux of happenings than the larger center. This is the great advantage of these homes, and FDC-givers are protective of the privacy and degree to which outside influences affect their environment. While these conditions offer many benefits for children, they also made it more difficult for the project to establish the communication and trust necessary to assist these homes to make optimal use of community health services and resources. This difficulty was compounded by the fact that the center program was a very ambitious one, and drew virtually all the time and staff available to the project during its three-year tenure. Creating a completely different program for FDC was beyond our resources, yet family day care homes had different needs than centers. For example, it was difficult and sometimes undesirable for FDC-givers to acquire a substitute to look after the FDC children while they attended a workshop at a center. Consequently, the program for FDC was very different from the program for the centers.

The project tried several approaches. In the first two years of the project, family day care assignments were added on to center assignments, with many staff members having one or more homes to work with. In the last year, the staff member who had most interest in and rapport with family day caregivers was assigned to work with all FDC homes (in addition to working with one center). With the help of one evaluation specialist and the back-up of an interdisciplinary team, this coordinator worked out a more consistent approach to working with family day care, including assessing FDC needs, establishing informal goals, and providing bi-weekly consultant services. By the end of the third year, a link had also begun to be established between some family day care homes and one center.

In all, FDC-givers required a longer period for building relationships with the the project than did center staffs and called for a more individualized approach, including home visits, for service delivery. By the end of the third year, the project had not developed as complete a model for work with homes as for work with centers, but had begun to extablish the network links it desired between homes and the project. Generally, the project developed individualized and varied approaches to use with FDC-givers.

Service Coordination Efforts and Their Impact

Our first-year goal of having agencies deliver services directly to the centers helped by project coordination was overly ambitious--agencies simply were not willing to so completely alter their delivery methods. Realizing this, in the second and third years the project turned to a broader, two-pronged approach to service delivery. The project developed innovative methods for service delivery, provided some services itself, and contracted with agencies for other direct services as needed.

We began by becoming well informed about, and familiar and experienced with, the human service resources in the community. From this base we worked to develop relationships and communication between line staff at the various agencies.

Eventually three channels were developed to facilitate this process. First was the advisory committee to the project. This committee was widely representative of agency resources in the community and provided visibility for resource providers. Second, during the second project year the local Community Coordinated Child Care (4-C's) affiliate, Child Care Coordinating and Referral Service (CCCRS), began to hold meetings to consider organizing a resources consultation network. This initially resulted in a committee of interagency staff members, supported by their respective agency directors, which published short- and long-term recommendations for increasing coordination of services among Washtenaw County agencies. These first two efforts generated a third opportunity for agency resources to get together: the intermediate school district representative, who attended both meetings, began to host luncheon discussions where resource people described to one another the services, and the regulations affecting those services, available through their agencies.

As a result of project efforts, day care directors were able to use more resources and to use them in a more selective and consistent manner because agency services were made clear and because less overlap in their services existed. As centers came to value this, they too helped agencies coordinate services by requesting various kinds of collaborative services.

Project staff also assisted CCCRS in developing and disseminating a Washtenaw County resource guide for children and their parents, "The Children's Yellow Pages," (Appendix A18) which further boosted agency use.

A major result of early project advisory committee and CCCRS consultant meetings was the Consultation Referral Service coordinated by CCCRS. This is an interagency network of consultants organized to enhance the quality, availability, and delivery of consultation services to caregivers of children from birth to five years. A copy of the pamphlet which publicizes the consultation referral network is included in Appendix A20.

Another major coordination effort was begun in the third year of the project. A staffing agreement was reached between CMH, CCCRS, and the project, whereby two half-time staff members from the same CMH team worked half-time with CCCRS and the project respectively. This fulfilled an original project goal of involving community agency staff directly with the project as a means of expanding use of the project's methods of service delivery. The CMH person attached to the project became the social work member of one team and served several centers. She found the team experience very salutary and is trying to continue some form of it in post-project CMH service to the day care community. This interest and support from CMH greatly aided the growth of coordinated services in the community and also helped the spread and adaptation of the project's interdisciplinary methods and materials.

The project made a final coordination effort with centers and agencies to promote continued use and adaptation of the project's methods and materials. As part of this coordination effort, in the early fall of the third project year, two persons from each agency (CMH, WPH, ISD, and CCCRS) were trained in the use of the DIAL. These staff are now part of the Consultation Referral Service coordinated by CCCRS. CCCRS will use the project's interdisciplinary training materials to provide training and referral to day care centers and public agencies serving young children and their families and will coordinate adaptation of project methods and materials for community use in the future.

The project's coordination efforts affected the community in three ways. The project strengthened community coordination of resources for young children and their families; enhanced the reciprocal awareness and use of the community's institutional resources and day care centers; and in the process, developed innovative methods and materials that day care and resource providers could use.

On a state and national level the project's methods and materials are timely and have potential for future use. In Michigan, the Interagency Committee for Services to High Risk Children and their Families is planning to increase interagency screening, some in the day care population. Title XX funds have been appropriated in the Michigan legislature to begin a large training effort of day caregivers, and some of the project's principles, methods, and materials will certainly be used. On a national level, the new Federal Interagency Day Care Regulations mandate training of caregivers, and the project materials on health have already been cited as directly on target for this kind of training. Also in the federal sphere is the future enactment and implementation of the Child Health Assessment Program (CHAP). The project's methods and materials can be a valuable resource for the design and implementation of a child health policy as it relates to the children in day care and the community's agency linkages to the day care facilities.

Conclusions and Recommendations

CONCLUSIONS	RECOMMENDATIONS
We conclude that:	We recommend that:
1) Making comprehensive[1] health assessment available on-site at day care centers is an effective avenue for reaching children in need, and for involving center staff and parents in securing follow-through.	1) A comprehensive health assessment procedure be provided in day care facilities and be adapted according to each community's specific needs. For example, for Washtenaw County it is recommended that hearing, vision, dental, and developmental assessments be routinely provided.
2) The DIAL is a more effective developmental assessment for identifying children with potential problems than the Denver if consultants are available for interpretation and follow-through.	2) To find and assist children with potential developmental problems, the DIAL can be used if appropriate consultation for interpretation and follow-through is available.
3) An on-site dental screen, headed by a dentist, is more effective than the conventional EPSDT procedure of referring for dental care.	3) An on-site dental screen, done by a dentist, be conducted at day care facilities.

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[1] Comprehensive has two meanings in this report. It refers to: 1) Methods, including outreach, assessment, and follow-up which include case monitoring and long-term follow-through; 2) A "whole child" philosophy of health: health is seen as an interdependent relationship between physical, cognitive, social, emotional, and environmental aspects of the child's development.

Conclusions and Recommendations (continued)

CONCLUSIONS	RECOMMENDATIONS
We conclude that:	We recommend that:
4) The project's approach to assessment and follow-through by interdisciplinary teams is of particular value for identifying and assisting children with nonreferrable problems.	4) To find and assist children with problems that are not serious enough now for referral but deserve attention so as to prevent future problems, assessment and ongoing consultation which incorporates parent and caregiver input be provided.
5) The project's comprehensive and interdisciplinary approach provides for continuity in the follow-through process for referrable problems.	5) On-site assessments, incorporating parent and caregiver input, be provided with ongoing coordinated interdisciplinary consultative support for day care staff and parents to secure follow-through for children with referrable problems.
6) The project's interdisciplinary and consultative approach to assessing the "whole child's" development also provides a means for reviewing social-emotional needs.	6) Day care consultants should use the persons who are closest to the child (i.e., parent and caregiver) to assist in assessment of social-emotional problems and for referral and/or remediation.

Conclusions and Recommendations (continued)

CONCLUSIONS	RECOMMENDATIONS
We conclude that:	We recommend that:
7) Carefully selected workshops based on need do not in themselves provide the necessary education for improving caregiver skills in working with children. However, if on-site consultation is interwoven with workshops, learning is reinforced and an increased utilization of training results.	7) A combination of training and consultation approaches be integrated for most effective caregiver training to meet the needs of children and their families.
8) Increased day care center use of community resources increases community support of day care as an effective resource and as support for the family.	8) Day care facilities and community resources be in close contact to increase the effective use of each other's resources.
9) Coordination of existing community resources serving the day care population allows informed, efficient, and effective use of those resources for children in day care and their families.	9) Coordination of resources serving the day care population be increased to improve communication, information exchange, and use of existing resources.
10) Consultation is basic to the generation and implementation of resource coordination and to the replication of the project's approach.	10) Available consultation resources in individual communities be used to coordinate resources and to increase the effectiveness of services for young children and their families.

City/University EPSDT*-Day Care Project

APPENDIX A

PROJECT OPERATION MATERIALS

SUITE 220, CITY CENTER BUILDING
220 E. HURON ST.
ANN ARBOR, MICHIGAN 48104

TELEPHONE:
(313) 764-0342

Third Project Year 1978-79

LONG TERM GOAL

To demonstrate and test a method for improving the identification and follow-up of children with remediable physical, intellectual or social-emotional difficulties and for maximizing the developmental growth of all children in this day-care population through appropriate treatment and programming.

SHORT TERM GOAL

1. With permission of parents, to determine the medical situations of each child in a population of eight day care centers and fifteen day care homes.
    a. The project will provide comprehensive on-site medical screening (EPSDT) for children not screened within the last year.
    b. Secure assess to medical records on all other children.
    c. Determine need for follow-up of specific health conditions.
    d. Help centers institute a consistent medical record system.
2. To provide a developmental assessment for each child in the population whose parent has given consent.
3. To provide referral to community resources for diagnosis and treatment for any child for whom screening suggests a physical handicap or developmental delay and to monitor the results of these referrals.
4. To provide a multidisciplinary team from education, social work, child development and nursing which will offer on-site instruction to caregivers so that the day care program in each of the facilities will meet the needs and foster the development of the children in their charge.
    a. Staff will become familiar with each center and home's operation through observation and interviews.
    b. The findings of the developmental assessments will be a spring board from which the day care and home program for all the children may be enriched.
        (1) A narrative description of each child's performance on the assessment will be provided for each caregiver and parent.
        (2) A composite developmental profile of a classroom will be drawn.
        (3) A group of activities relating to each of the four areas covered by the assessment, gross motor, fine motor, concepts, and communication will be provided each caregiver and parent.

c. The general underlying goals of the training offered will be to improve caregivers skills and knowledge of child development, program planning, guiding children's behavior, health and safety and nutritional concerns, and working with parents.

   (1) A major approach to training will be workshops that center around the aforementioned activities as they relate to children's individual developmental levels.

   (2) Consultation around problematic behavior of individual children as reported by the caregivers, will be provided. The importance of providing a healthy social-emotional environment for all children will be an intrinsic part of training and consultation.

   (3) The medical needs of each unit in the area of health policy and health education will be assessed by the medical members of the team and determine the approach to that training in each unit.

d. Training which will usually take place on-site will be led by the professional most related to a particular topic, but there will be cross discipline consultation.

e. The above approaches to training will be set down for possible replication elsewhere.

5. To strengthen and support the relationship between the centers and parents using the community coordinator as liaison and facilitator.

   a. Parents will share in all decisions relative to screening, further diagnosis and planning for their child; caregivers will be urged to set up regular conferences in which screening results and activities for home and school are discussed.

   b. Project will support and help to facilitate continuing communication between caregivers and parents around children's growth and development and program in the home and in the center.

   c. The community coordinator, with appropriate members of the multidisciplinary team, will assist the center in helping parents locate and use community resources.

6. To demonstrate a method for increasing service and consultation by human service agencies to day care by the use of the project's multidisciplinary team.

   a. Make linkages to appropriate public agencies (Community Mental Health, Public Health, The Ann Arbor Public Schools, Department of Social Services), through the project's community practitioners in the relevant discipline, and other project staff.

   b. Establish referral and follow-up procedures with these agencies and maximize the use of these agencies as they relate to preschool children and their families.

   c. Compile information gathered from our population about the relevance and responsiveness of this community's services for young children.

/tmp

CAREGIVER QUESTIONAIRE

HEALTH	Current Skill Level				Importance				Effectiveness of Project				Would you like help from the Project in this area?	
	Unfamiliar with this area	Have begun to develop skill in this area	Have acquired a fair amount of skill in this area	Am quite skilled in this area	Not important	Somewhat important	Important	Essential	Ineffective	Somewhat effective	Moderately effective	Very effective	Yes	No
	(1)	(2)	(3)	(4)	(1)	(2)	(3)	(4)	(1)	(2)	(3)	(4)	(Y)	(N)
A1. Knowing what pre-schoolers need (e.g., rest, exercise, diet) to maintain good health.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
A2. Recognizing the symptoms of common childhood diseases and health problems.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
A3. Planning activities to teach children about good health habits.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
A4. Taking care of a sick child.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
A5. Locating medical services for children and their families.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
A6. Keeping readily available records of children's health examinations or records.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N

CAREGIVER QUESTIONAIRE

SAFETY

	Current Skill Level				Importance				Effectiveness of Project				Would you like help from the Project in this area?	
	Unfamiliar with this area	Have begun to develop skill in this area	Have acquired a fair amount of skill in this area	Am quite skilled in this area	Not important	Somewhat important	Important	Essential	Ineffective	Somewhat effective	Moderately effective	Very effective	Yes	No
	(1)	(2)	(3)	(4)	(1)	(2)	(3)	(4)	(1)	(2)	(3)	(4)	(Y)	(N)
B1. Knowing the common causes of accidents/ injuries in day care centers.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
B2. Recognizing safety hazards in your center.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
B3. Planning activities to teach children about safety.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
B4. Helping children prevent accidents by modeling safe work and play habits.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
B5. Finding resource people (e.g., policemen, firemen) who can talk to the children about safety.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
B6. Developing a system for routine safety checks to detect potential safety hazards in the center.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N

CAREGIVER QUESTIONAIRE

NUTRITION	Current Skill Level				Importance				Effectiveness of Project				Would you like help from the Project in this area?	
	Unfamiliar with this area (1)	Have begun to develop skill in this area (2)	Have acquired a fair amount of skill in this area (3)	Am quite skilled in this area (4)	Not important (1)	Somewhat important (2)	Important (3)	Essential (4)	Ineffective (1)	Somewhat effective (2)	Moderately effective (3)	Very effective (4)	Yes (Y)	No (N)
C1. Knowing the developmental food habits of preschool children and what is needed for a well-balanced diet.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
C2. Being aware of problems in an individual child's eating habits.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
C3. Utilizing nutritious foods in daily programming (e.g. snacks, stories, arts, teaching concepts).	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
C4. Helping children develop a positive attitude toward eating nutritious food.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
C5. Obtaining free or inexpensive information and consultation regarding planning meals and snacks that are nutritious and appealing.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
C6. Keeping track of the kinds of food served for lunches or snacks.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N

CAREGIVER QUESTIONNAIRE

GROSS MOTOR	Current Skill Level				Importance				Effectiveness of Project				Would you like help from the Project in this area?	
	Unfamiliar with this area	Have begun to develop skill in this area	Have acquired a fair amount of skill in this area	Am quite skilled in this area	Not important	Somewhat important	Important	Essential	Ineffective	Somewhat effective	Moderately effective	Very effective	Yes	No
	(1)	(2)	(3)	(4)	(1)	(2)	(3)	(4)	(1)	(2)	(3)	(4)	(Y)	(N)
D1. Knowing the normal progression of gross motor skill development in children.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
D2. Recognizing actions that reflect the child's developmental level in the gross motor area and/or indicates a possible orthopedic problem.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
D3. Planning activities that will help children develop (and not hurt) their large muscles.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
D4. Working with children who need special help or practice in physical activities such as hopping, balancing, etc.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
D5. Obtaining free or inexpensive materials which can be used to build gross motor equipment.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
D6. Keeping track of each child's progress in developing gross motor skills (e.g., using a developmental checklist).	1	2	3	4	1	2	3	4	1	2	3	4	Y	N

CAREGIVER QUESTIONNAIRE

FINE MOTOR

	Current Skill Level				**Importance**				**Effectiveness of Project**				Would you like help from the Project in this area?	
	Unfamiliar with this area	Have begun to develop skill in this area	Have acquired a fair amount of skill in this area	Am quite skilled in this area	Not important	Somewhat important	Important	Essential	Ineffective	Somewhat effective	Moderately effective	Very effective	Yes	No
	(1)	(2)	(3)	(4)	(1)	(2)	(3)	(4)	(1)	(2)	(3)	(4)	(Y)	(N)
E1. Knowing the normal progression of fine motor skill development in children.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
E2. Recognizing signs that a child is having trouble with perceptual-motor activities.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
E3. Planning activities that will help children develop their perceptual-motor skills.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
E4. Working with children who need special help or practice in perceptual-motor activities.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
E5. Obtaining free or inexpensive materials for manipulative activities.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
E6. Keeping records of each child's progress in developing fine motor skills (e.g., filing representative pieces of art work).	1	2	3	4	1	2	3	4	1	2	3	4	Y	N

CAREGIVER QUESTIONAIRE

CONCEPTS	Current Skill Level				Importance				Effectiveness of Project				Would you like help from the Project in this area?	
	Unfamiliar with this area	Have begun to develop skill in this area	Have acquired a fair amount of skill in this area	Am quite skilled in this area	Not important	Somewhat important	Important	Essential	Ineffective	Somewhat effective	Moderately effective	Very effective	Yes	No
	(1)	(2)	(3)	(4)	(1)	(2)	(3)	(4)	(1)	(2)	(3)	(4)	(Y)	(N)
F1. Knowing the normal progression of concept development (e.g. size, shape, color) in children.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
F2. Recognizing a child's current level of concept development.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
F3. Planning activities that are appropriate to each child's level of concept development.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
F4. Helping children use play materials in a way that will help them develop concepts such as size, shape, etc.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
F5. Using the natural community environment (nature trails, libraries, etc.) to facilitate cognitive development.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
F6. Developing a way of keeping records that will trace each child's progress in concept development.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N

CAREGIVER QUESTIONAIRE

COMMUNICATION	Current Skill Level				Importance				Effectiveness of Project				Would you like help from the Project in this area?	
	Unfamiliar with this area	Have begun to develop skill in this area	Have acquired a fair amount of skill in this area	Am quite skilled in this area	Not important	Somewhat important	Important	Essential	Ineffective	Somewhat effective	Moderately effective	Very effective	Yes	No
	(1)	(2)	(3)	(4)	(1)	(2)	(3)	(4)	(1)	(2)	(3)	[illegible]	(Y)	(N)
G1. Knowing what can be expected at each age in terms of children's abilities to communicate with others.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
G2. Being able to detect language or speech problems in children.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
G3. Planning activities (e.g., socio-dramatics, music) that give children practice in communicating with adults and with other children.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
G4. Talking with children in a way to facilitate their language development.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
G5. Locating resources for children with language or speech problems.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
G6. Making notes of each child's language development and specific speech problems.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N

CAREGIVER QUESTIONAIRE

SOCIAL-EMOTIONAL

	Current Skill Level				Importance				Effectiveness of Project				Would you like help from the Project in this area?	
	Unfamiliar with this area	Have begun to develop skill in this area	Have acquired a fair amount of skill in this area	Am quite skilled in this area	Not important	Somewhat important	Important	Essential	Ineffective	Somewhat effective	Moderately effective	Very effective	Yes	No
	(1)	(2)	(3)	(4)	(1)	(2)	(3)	(4)	(1)	(2)	(3)	(4)	(Y)	(N)
H1. Knowing what can be expected at each age in terms of social/emotional development.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
H2. Recognizing and interpreting behaviors in children which reflect their particular emotional needs.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
H3. Scheduling activities and using space to ensure that children's individual needs are met.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
H4. Responding to children in a way that helps them feel secure, cared for and important.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
H5. Assisting families to locate help when they need or want guidance concerning their children.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
H6. Keeping track of progress a child is making in terms of emotional development (e.g., learning to control temper).	1	2	3	4	1	2	3	4	1	2	3	4	Y	N

CAREGIVER QUESTIONAIRE

PARENT-INVOLVEMENT

	Current Skill Level				Importance				Effectiveness of Project				Would you like help from the Project in this area?	
	Unfamiliar with this area	Have begun to develop skill in this area	Have acquired a fair amount of skill in this area	Am quite skilled in this area	Not important	Somewhat important	Important	Essential	Ineffective	Somewhat effective	Moderately effective	Very effective	Yes	No
	(1)	(2)	(3)	(4)	(1)	(2)	(3)	(4)	(1)	(2)	(3)	(4)	(Y)	(N)
11. Knowing about the connection between the child's life at home and the child's life at the center.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
12. Recognizing behaviors and feelings in parents and yourself which influence center-parent relationships.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
13. Planning activities and projects that involve parents either at the center or at home.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
14. Working cooperatively with a parent in the interests of his or her child.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
15. Helping parents locate and make use of community services for children or themselves.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
16. Keeping on record and using information about families (e.g.,work schedules, interests, etc.) which can be useful in facilitating parent involvement.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N

CAREGIVER QUESTIONAIRE

STAFF-INTERACTION

	Current Skill Level				Importance				Effectiveness of Project				Would you like help from the Project in this area?	
	Unfamiliar with this area	Have begun to develop skill in this area	Have acquired a fair amount of skill in this area	Am quite skilled in this area	Not important	Somewhat important	Important	Essential	Ineffective	Somewhat effective	Moderately effective	Very effective	Yes	No
	(1)	(2)	(3)	(4)	(1)	(2)	(3)	(4)	(1)	(2)	(3)	(4)	(Y)	(N)
J1. Knowing how your relationship with the adults in the program affects the children.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
J2. Recognizing when your own problems in staff relationships are affecting the children.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
J3. Developing programs that make use of individual staff members' special strengths and interests (e.g., musical or painting abilities).	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
J4. Relating to the adults in the program in a way that can serve as a model for the children.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
J5. Locating and using community resources for inservice training and staff development.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
J6. Using record keeping as a way of keeping staff informed of each child's progress and problems.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N

INSTRUCTIONS FOR THE ADMINISTRATION OF THE CAREGIVER QUESTIONNAIRE

(to be read to the caregiver, while the questionnaire is demonstrated)

Look at the first page. Here are six skills in the health areas which may be useful for a day care giver to develop. On the following pages there are a total of ten such areas, such as fine motor, cognitive skills, etc. No one is expected to be skilled in all these areas. We are only making certain that we have included all the areas that may be relevant to day care.

The first question, A-1, is "knowing what pre-schoolers need (e.g. rest, exercise, diet) to maintain good health." You can see that you are asked to respond to each skill level, in FOUR different ways.

First, consider what you feel is your current skill level in this area . There are four possible responses to this question. (Point to numbers 1,2,3,4 as you read, to reinforce scale.)

(1) are you unfamiliar with this area?
or (2) have you begun to develop skill in this area?
or (3) have you acquired a fair amount of skill in this area?
or (4) are you quite skilled in this area?

Choose the response, 1,2,3, or 4, that best describes how you feel your current skill level is, of knowing what pre-schoolers need to maintain good health.

Then circle the corresponding number, on the same line as question A-1 in the first column. (Check to see that the caregiver does this and correct the use of strokes, etc., on the answer sheet.)

The second way you are asked to respond to each skill level, is as to how important you feel it is for YOU , as a caregiver, to have this skill. Again, you see that there are four possible responses to this question : "Knowing what pre-schoolers need to maintain good health" is,

(1) not important,
or (2) somewhat important,
or (3) important,
or (4) essential?

Choose the response, 1,2,3 or 4, that best describes how important you feel it is for you, as a caregiver, to know what preschoolers need to maintain good health..

Then circle the corresponding number, on the same line as question A1, in the second column.

Were you in the Project last year?
(if NO, go to Column 4, (next page of instructions)
(if YES, continue instructions this page.)

The third way you are asked to respond to each skill level, is how effective you feel the project has been in helping you to develop your skill in knowing what pre-schoolers need to maintain good health? The four responses are:

(1) The Project has been ineffective,
or (2) The Project has been somewhat effective,
or (3) The Project has been moderately effective,
or (4) The Project has been very effective?

Choose the response, 1,2,3 or 4, that best matches your experience in the past year, with the Project.

Then circle the corresponding number, on the same line as question A1, in the third column .

Last, you are asked whether you would like help from the Project in this area of health in this coming year? If you would like any kind of assistance from the Project staff, informal or otherwise, circle (Y) for yes in column 4.

As you work through this questionnaire, put an answer in each column, for each skill area (with the exception of column 3, if you were NOT in the Project this past year).

Do not leave out any skill areas or questions, for any other reason. As soon as you complete a page, go on to the next one, and fill it in the same way.

If there is anything you would like to add to this questionnaire, use the space at the bottom of the page for your comments.

Feel free to ask for an explanation of any item as you go through the ten pages of skills and questions.

VALIDATION OF THE CAREGIVER QUESTIONNAIRE

Development of the Questionnaire

The conceptual background for the Caregiver Questionnaire is represented by the Topic/Skill matrix shown in Figure 1, which, in turn, was developed following an examination of the project training objectives and of the workshop curricula from the second project year. The essential idea of the matrix is that the six skill areas are always taught within the context of one of the ten topic areas and that teaching any topic area always involves the six skill areas; thus, for any topic x skill cell of the matrix it ought to be possible to identify a teachable activity. In order to test this assumption, the project staff were asked to try to identify examples of training activities for each cell of the matrix. Each discipline group (nurses, educators, and social workers), worked within their own areas of expertise and then reviewed each other's work to produce a complete set of examples.

Using the final set of worksheets produced by the project staff, the evaluators constructed item stem phrases for each cell of the matrix. Determining an appropriate level of specificity and maintaining consistency of that level was a particularly difficult and time-consuming task. For example, for the A2 cell (Health x Observation), "recognizing a sick child" was too general and "recognizing measles symptoms" was too specific. The closer the item was to the specific end of the continuum, the greater the number of possible items (e.g., measles, mumps, chicken pox, etc.) and the greater the need for representativeness of the item. Several sessions were held between evaluators and project staff until there was general agreement regarding the content and level of specificity for each phrase.

These 60 items were designed to produce measures, not of each individual cell of the Topic/Skill matrix, but rather measures of the ten topic areas and six skill areas. Topic area indices were built by finding the mean of the six skill areas within each topic area; likewise, skill area indices were built by finding the mean of the ten topic areas within each skill area.

Once the item stems were developed, the evaluation team, working with the project staff, identified four questions to be asked about each item stem. These questions addressed:

1) the caregiver's perception of his/her own skill level.

2) the caregiver's perception of the importance of the skill.

FIGURE 1: ITEM CONTENT MATRIX

TOPICS FOR CAREGIVER TRAINING

DEVELOPMENTAL SKILLS: GROSS MOTOR, FINE MOTOR, CONCEPTS, COMMUNICATION

HEALTH
SAFETY
NUTRITION
GROSS MOTOR
FINE MOTOR
CONCEPTS
COMMUNICATION
SOCIAL/EMOTIONAL DEVELOPMENT
PARENT INVOLVEMENT
STAFF INTERACTION

1. KNOWLEDGE	(Basic information needed prior to application)
2. OBSERVATION	(Recognizing, detecting, assessing, diagnosing specific behaviors or problems)
3. PROGRAM PLANNING	(Matching activities to abilities, using materials appropriately, organizing ideas for program implementation)
4. INTERACTION	(Building rapport or relationship, modeling, managing, presenting, implementing planned activities)
5. USE OF COMMUNITY RESOURCES	(Finding resources appropriate to needs, facilitating family contacts with community agencies)
6. RECORD KEEPING	(Developing and/or maintaining a record-keeping system to chart progress or changes, using records in planning)

3) the caregiver's rating of the project's effectiveness during the previous year.

4) whether or not the caregiver wished help in the area during the next year.

A pilot test of the questionnaire with an inexperienced day care worker, a family day care mother with some experience working with children, and an experienced day care center director produced results for perceived skill and importance (the only questions used in the pilot) in the expected direction for all skill area indices and all topic area indices.

Administration of the Questionnaire

The questionnaire was administered to 51 caregivers from the centers enrolled in the project. Somewhat less than half (40%) of these caregivers had been employed by their center for at least one year and, thus, could be viewed as having more exposure to the project and possibly more experience than the rest of the caregivers. The questionnaire was administered individually in some centers and in groups, usually during staff meetings, in others, depending on the preference of the center director. In either case, a member of the evaluation staff was present to explain the questionnaire, to answer questions, and to ensure that the questionnaires were completed properly.

For the most part, caregivers in the centers had little trouble with the wording of the items. However, some family day caregivers had more difficulty understanding some of the items. These caregivers were generally newer to the project and less involved with, for example, developmental screening; as a result they were probably less familar with the terminology used by the project staff than were caregivers in regular centers. This suggests that for any subsequent uses of the questionnaire outside this project, consideration would have to be given to whether the items might have to be adapted to a wider variety of experiences or reading levels. The advantage of the conceptual framework behind the questionnaire becomes clear in this case: new items can be developed for any cell of the matrix and still produce measures of the indices which would be reasonably comparable.

Validation of the Questionnaire

The validation focused on two basic questions: 1) was the matrix of topic and skill areas from which the questionnaire was constructed actually getting at areas relevant to the needs of the day care personnel; and 2) was the concept of measuring topics across a range of skill areas and skills across a range of topics a viable one.

Relevance. The process of developing the items themselves provided some indication of the relevance of the matrix, in that the project staff was able to provide an example of possible training activities for each cell of the matrix. Thus, these are areas where it is possible for training to take place. The results of the importance rating section of the questionnaire provide further evidence--mean importance ratings for topic and skill areas ranged from 3.2 to 3.6 out of a possible 4 points, indicating that the caregivers felt these areas were of importance to their role as a caregiver. In fact, there were only 3 out of the 60 items with means less than 3.

Validity of the topic and skill indices. From the pretest data set, the question of "validity" can be examined from three standpoints: reliability, "face validity," and concurrent validity (family day caregiver responses are not included in the data reported here). Face validity will be based on the reasonableness of the obtained patterns of means.

Reliability. The reliability of the indices was measured using Cronbach's Alpha, a test of the internal consistency of items within an index. Alpha is comparable to a parallel form reliability and should be interpreted in the same way--as the proportion of true score variance accounted for by the observed measure.

For these data, Alphas for all indices were in the range .80-.93 for the skill rating portion of the questionnaire; .76-.93 for importance ratings; and .78-.93 for requests for help (see Table 1). An additional measure of internal consistency, the correlations of the individual items to their index, produced generally moderate to high correlations, usually between .50 and .75, although a few dropped into the .30's and, in one case, to .19. Dropping items from any one of the indices did not substantially increase or decrease the Alphas. Thus, the items on the questionnaire provided reliable estimates of the indices.

It should be pointed out that the indices are themselves highly correlated. This is to be expected, since every topic area is made up of the same skill areas, each of which have a high internal consistancy. These intercorrelations illustrate the point that, while the indices may be conceptually independent for purposes of evaluation and needs assessment, statistically and in actual practice they are interrelated.

Face Validity. The procedures used here are rather ad hoc and certainly not definitive. They simply ask whether the patterns of means which occurred for the topic and skill area indices make sense. One would expect, for example, that more experienced caregivers would tend to rate their

Table 1 : Reliability/Internal Consistency Measures for Topic and Skill Indices, from the Skill, Importance, and Help Sections of the Caregiver Questionnaire

	Skill		Importance		Help	
Index	Alpha	Range of Item to Index Correlations	Alpha	Range of Item to Index Correlations	Alpha	Range of Item to Index Correlations
Health	.86	.48 - .81	.76	.19 - .60	.81	.34 - .69
Safety	.84	.42 - .73	.81	.48 - .66	.80	.45 - .71
Nutrition	.86	.58 - .76	.80	.46 - .71	.78	.35 - .70
Gross Motor	.85	.57 - .66	.87	.62 - .74	.85	.48 - .84
Fine Motor	.89	.53 - .80	.86	.45 - .82	.83	.36 - .69
Concepts	.82	.47 - .73	.91	.68 - .88	.83	.29 - .81
Communication	.83	.55 - .68	.88	.62 - .74	.84	.44 - .82
Social/Emotional	.87	.64 - .77	.91	.50 - .82	.91	.49 - .85
Parent Involvement	.90	.62 - .79	.87	.57 - .76	.90	.63 - .89
Staff Relations	.85	.50 - .77	.90	.63 - .81	.93	.62 - .90
Knowledge	.88	.43 - .80	.86	.30 - .74	.89	.47 - .81
Observation	.91	.53 - .79	.91	.37 - .82	.90	.36 - .83
Program Planning	.88	.44 - .73	.88	.38 - .79	.86	.34 - .83
Interaction	.87	.33 - .70	.88	.33 - .83	.89	.43 - .79
Community Resources	.93	.61 - .87	.91	.51 - .75	.84	.33 - .68
Record-Keeping	.91	.53 - .79	.93	.52 - .85	.84	.28 - .70

skill somewhat higher than would inexperienced caregivers. This, in fact, occurred in the pilot testing of the questionnaire, when we had direct information about amount of experience. Similar results occured for our group of 51 caregivers, for whom we had at least some information about length of employment at their center. These results appear in Table 2.

Those caregivers designated "old" caregivers were those who had taken part in interviews one year previously and thus had been with their center at least one year; those designated "semi-new" had been in their center for less than a year but probably more than 6-8 months; those designated "new" had been with their center less than a year and probably less than 6 months. Whether these distinctions represent differences in amount of exposure to the project or differences in experience is not completely clear.

Examination of the means indicates a consistent (and statistically significant--multivariate $F(10,36)=2.15$, $p<.05$) linear trend from new to old. (Note: because the "semi-new" group was so small, statistical tests were based only on the "new" and "old" groupings). The old group definitely views itself as more skilled than does the new group.

A second pattern of interest appears in the means for the six skill areas. The highest means are for the areas of Knowledge, Observation, and Interaction, with Program Planning also being fairly close. These areas probably impact much more on the everyday activities of the caregivers than do contacts with community resources and record-keeping; one would expect caregivers to be more skilled in these areas, or at least to feel that they should be. A similar but less pronounced pattern occurred for the mean importance ratings.

Concurrent validity. The only measures of concurrent validity available from the pretest data set are the ratings of caregiver skill made by the center directors and the project staff. Directors and project teams were asked to estimate how many of their staff (none, some, most, all) in their centers had a "fair amount of skill" in the area indicated by the item. As indicated in Table 2, the mean response by directors followed the same pattern as the mean caregiver responses. Director mean responses, most of which were 3.0 or higher, were also consistent with caregiver item responses, in which a majority of caregivers rated themselves at the 3 or 4 level for all items except those involving record-keeping and community resources. Project team ratings, however, tended not to agree either in magnitude or, more importantly, in pattern with the director's ratings. Whether this is the result of differences in familiarity with the caregivers in the center

TABLE 2: MEAN SKILL RATINGS BY TOPIC AND SKILL AREA FROM QUESTIONNAIRE RESPONSES OF CAREGIVERS, DIRECTORS, AND PROJECT STAFF.

	Caregivers								Directors		Project Staff	
	New		Semi-New		Old		Total					
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
A. Health	2.4	.7	2.7	.3	3.1	.5	2.7	.7	3.2	.5	2.5	.7
B. Safety	2.5	.6	2.9	.4	3.1	.6	2.8	.7	3.1	.4	2.1	.4
C. Nutrition	2.8	.6	3.2	.3	3.3	.6	3.0	.6	3.4	.4	2.5	.4
D. Gross Motor	2.4	.7	3.0	.7	2.9	.5	2.7	.6	3.0	.7	2.6	.6
E. Fine Motor	2.3	.8	2.7	.9	2.9	.6	2.6	.8	2.7	.6	2.7	.6
F. Concepts	2.6	.6	2.7	.5	3.1	.5	2.9	.6	3.0	.5	2.7	.6
G. Communication	2.5	.5	2.7	.5	3.2	.6	2.8	.6	3.0	.5	2.8	.7
H. Social/Emotional	2.8	.6	2.8	.4	3.4	.4	3.0	.6	3.3	.6	2.7	.8
I. Parent Involvement	2.2	.8	2.7	.9	3.1	.6	2.6	.8	3.1	.5	2.7	.8
J. Staff Interaction	2.6	.7	2.7	.5	3.2	.5	2.9	.7	3.1	.6	2.8	.9
Knowledge	2.8	.6	2.8	.4	3.4	.4	3.0	.6	3.2	.5	2.7	.6
Observation	2.8	.6	2.9	.4	3.2	.4	3.0	.6	3.1	.4	2.6	.6
Program Planning	2.5	.6	2.9	.5	3.2	.5	2.8	.6	3.2	.4	2.6	.8
Interaction	2.8	.5	3.2	.6	3.3	.5	3.0	.5	3.4	.4	2.7	.6
Community Resources	2.1	.8	2.4	.6	2.8	.6	2.4	.8	2.8	.5	2.5	.5
Record Keeping	2.1	.7	2.7	.5	2.9	.6	2.5	.7	2.8	.8	2.8	.8
	N=25		N=5		N=21		N=51		N=8		N ranged from 7-11	

or of a validity problem with the questionnaire is uncertain.

Summary

The results of this validation study provide evidence that the questionnaire is a reasonably valid measure of caregivers' perceptions of their own skill in areas relevant to day care. It provides internally consistent measures of perceived skill in topic and skill areas judged relevant to the caregivers' job responsibilities. The pattern of responses indicated in topic and skill indices is consistent with realistic expectations. The center directors as a whole tend to share the perceptions of their staffs.

Measures based on self-perception always run the risk that the self-perceptions will not necessarily coincide with reality. However, ostensibly more objective procedures such as systematic observation have risks of their own in terms of obtrusiveness, reliablity, and validity, particularly when the events one is trying to observe (e.g., a caregiver's detection of a potential orthopedic problem in a child) may occur infrequently. Thus, the strategy of measuring caregiver skills via self-report and bolstering it with the anecdotal observations of the project teams is likely to be as valid as any of the apparently more "objective" procedures.

Appendix A 3

Health and Developmental History Prototype

Today's date: ____________ Enrollment date: __________

Child's name: __________________ Birthdate: _________ Age: _____ Sex: _____

Nickname: __________________

Address: ______________________________ City: ________________ Zip: _______

Father's name: ________________________ Mother's name: ______________________

Age: _____ Occupation: ______________ Age: _____ Occupation: ______________

Place of Employment: __________________ Place of Employment: ________________

Telephone: _______ Working hours: _____ Telephone: _______ Working hours: _______

With whom does child reside? _____Mother _____ Father _____ Other

If other, please explain: ____

How will your child be transported to and from school? __________________________

Other children in the family: Name(s) __________________ Age(s) ______________

__________________ ______________

Others who live with your family: Name(s) ______________ Age(s) ______________

Relationship(s) to child: ____

Pets in the family: _______________________ Names: ____________________________

Dentist's name: __________________________ Address: ___________________________

Telephone: ___________________________

Are parents in good health? ____

Was there anything unusual about the pregnancy with this child? _________________

____

Did the baby come on time? ____

Did this child require any special medical care or prolonged hospitalization at birth?

____

What was the birth weight? _______________

At approximately what age did your child ....

Sit alone _____
Crawl _____
Walk alone _____
Say first words _____
(what were they?) ____________________
Say first sentence _____
(two words or more) ____________________
Drink from a cup _____

Feed self with a spoon _____
Become toilet trained _____
Bladder _____
Bowel _____
Night time _____
Dress self _____
Button buttons _____
Snap snaps _____
Zip zippers _____
Tie shoelaces _____

Have either you or your doctor noted that your child has had:

_____ high fevers
_____ earaches
_____ toothaches
_____ nose bleeds
_____ frequent colds

_____ eczema
_____ hives
_____ wheezing
_____ vomiting
_____ diarrhea

_____ constipation
_____ seizures
_____ speech problems
_____ difficulty seeing
_____ difficulty hearing

If yes to above question, please explain how often it occurs, cause and treatment given.

____

____

Please specifically list all allergies including food, medication, insect bites or stings.

____

____

Has your child had any of the following childhood illnesses?

_____ Chicken pox
_____ 'Red' or 'Hard' measles
_____ 'German' or '3-day' measles
_____ Mumps

_____ Meningitis
_____ Strep throat
_____ Impetigo
_____ Pin worms

Does your child have any other medical or physical problems? ____________
If yes, please explain and give name of medical person treating condition:

____

____

Any medication given regularly? ____________________________________

Has your child ever been hospitalized or had surgery or been treated in the emergency room? _______

If yes, please explain: ____

____

When did your child last:

1. Have a regular medical check-up? ______________________
   Where? ______________________________
2. Have a dental check-up? ______________________
   Where? ______________________________

Does your child usually eat . . .

_____ Dairy products (milk, cheese)
_____ Meat
_____ Eggs
_____ Poultry
_____ Fish

_____ Soy bean products
_____ Grain products (bread, cereal)
_____ Fruit
_____ Vegetables
_____ Peanut butter

What are your child's food preferences/dislikes? ______________________

Does your child nap? _____ How long? _____

Best way to waken: ______________________

Does your child take anything to bed at naptime? ______________________

What words or gestures does your child use to indicate need to use the bathroom?

Names of your children's special friends: ______________________

What are your child's favorite toys, interests, TV programs or play activities?

What method of discipline do you use with your child? (e.g., send to room, sit in chair, no TV, spank, etc.)

____

____

Any previous experiences away from parents, including day care or preschool?

____

If yes, where? ______________________________

Does your child have a difficult time when you leave him/her? Explain. ____________

____

If so, how do you deal with it? ______________________________

____

If parents are not together, does child see absent parent? ____________

How often? ______________________________

Have there been any major changes at home that would affect your child? (e.g., death, separation, divorce, distant move)

____

Is your child afraid of anything? (e.g., animals, thunder storms, the dark, etc.)

If yes, please explain: ______________________________

____

____

Many children, when under stress, exhibit certain behaviors. Does your child. . .

_____ bite nails
_____ suck thumb or fingers
_____ wet the bed
_____ have nightmares
_____ have temper tantrums
_____ hold his/her breath
_____ twirl hair
_____ sleep walk

Are there skills, interests or hobbies you would be willing to bring to the center to share with staff or children? ______________________________

____

Would you be interested in attending parent meetings? What time is best for you?

____

____

Is there any special information which would help us take care of your daughter/son? (e.g., any specific activities to be encouraged or restricted, special goals for your child?)

What do you expect your child to get out of our program?

Appendix A4

Health Supervision Checklist

Name: ______________________

Birthdate: ______________________

Chronic Problems: e.g., allergy, asthma, seizures, nutrition/feeding, sleep, elimination

Conditions requiring emergency care: e.g., bee sting allergy

Continuous Medications:

(write year)	19						19						
Data Base (months)	Sp/Oc	Ny/De	Jn/Fe	Ma/Ap	My/Jn	Ju/Au	Sp/Oc	Ny/De	Jn/Fe	Ma/Ap	My/Jn	Ju/Au	Results/Follow-Up/Comments
Bi-monthly update of Emergency Card													
Bi-Yearly update of Health Appraisal (physical exam)													
Yearly update of Health Development Intake Form													
Screening Test--Every Year: (write numbers)													
Height													
Weight													
(check if done): Hearing Screen													
Developmental Appraisal													
Dental ⟩ screenings begin at 3 years													
Vision ⟩ screenings begin at 3 years													
Immunizations--write month/year (see Immunization Schedule)	1st dose (2 mo)	2nd dose (4 mo)	3rd dose (6 mo)	1 yr	15 mo	Booster (18mo)	2 yr	2 1/2	3 yr	3 1/2	Booster (4 yr	5 yr)	
DPT													
Oral Polio													
TB	▨	▨	▨										
Measles/Mumps/Rubella (Should not be given until child is 15 mos. If given before that, repeat dosage)	▨	▨	▨	▨									
Other:													
Chicken Pox yes ☐ no ☐													

*Code: Use red notations for special conditions or where follow-up is necessary

Appendix A5

TO ORIENT DAY CARE STAFF TO MEDICAL SCREENING:

I. WHAT IS IT?

A. Use Washtenaw County Medicaid Screening Team

1. Hearing/Vision Technician
2. Nurse
3. Laboratory Technician

B. Will Do

1. Health History
2. Hearing and Vision Screening
3. Laboratory Work

    (a) Urinalysis for Diabetes and Kidney Disease
    (b) Blood Test for Anemia, and Sickle Cell Disease
    (c) Lead Poisoning Screening

4. Physical Assessment by Nurse

    (a) EENT--increase or decrease in pupils (equal and reactive), good scleral color, redness, drainage
    (b) Blood Pressure, Pulse, Heart--increase or decrease in rate, murmurs
    (c) Skin and Hair--alopecia, ringworm, cradle cap, deviations, decreased turgor, lice
    (d) Height and Weight--increase or decrease for age, nutrition
    (e) Mouth and Teeth--odor, sores, caries
    (f) Abdomen--tenderness, rigidity, masses
    (g) Gait--falling, limping
    (h) Hands and Feet--cyanosis, clubbing
    (i) Genitalia--lesions, discharge, undescended testicle

C. How Staff can Help Prepare Children

1. Health Unit
2. Make or Borrow Equipment to "try" on Each Other

    (a) Otoscope, Ophthalmoscope
    (b) Stethescope
    (c) Tongue Blades
    (d) Reflex Hammer
    (e) Blood Drawing Equipment
    (f) Immunizations
    (g) Audio-Visual

D. Discuss Common Childhood Diseases

1. Measles
2. Mumps
3. Rubella
4. Chicken Pox
5. Roseola
6. Scarlet Fever
7. Impetigo
8. Ringworm, Lice

E. Problems Found Frequently in Screening at This Age Level

1. Heart Disease
2. Strabismus, Amblyopia (Eye Problems)
3. Dental Problems
4. Anemia
5. Kidney Disease
6. Short Stature
7. Lack of Immunizations

F. What We Will do With Results of Screening

1. Report to Parents
2. Results to Private Doctor if Parent Requests
3. Refer to Community Resource as Needed for Follow-up

    (a) Help in Locating Resources for Follow-up
    (b) Transport When Necessary
    (c) Help to Locate Funds, if Possible

4. Talk with Parent After Referred to see if Follow-up Done, Answer Questions, Help as Needed

MEDICAID SCREENING PROGRAM
HEALTH HISTORY - FOR CHILDREN UNDER SIX
*NOTE ADDITIONS

APPENDIX A6

Birthdate ____________
Race ____________

Child's Name ______________________________________

Address & County ____
Phone ____________

Parent or Guardian ____________ Address ______________________
(Circle correct)

Physician's Name ____________ Address ______________________
Phone ____________

Dentist's Name ____________ Address ______________________
Phone ____________

PERMISSION:

I hereby give my permission for the above-named child to receive health screening, immunization(s) and tuberculin testing as needed.

______________________ Signature

____________ Date

IMMUNIZATIONS and DATES

	1	2	3	4	5	6
DPT						
Polio (Type)						
Smallpox (Result)						
Red Measles						
Rubella						
Mumps						
Other						
TB Test						

Pregnancy and Birth History

1. Did you have an illness during your pregnancy? . . . . No Yes
2. Did the baby come on time? . . . . Yes No
3. What was the birth weight? . . . . __lbs. __ oz.
4. Did your baby have any trouble starting to breathe?. . . . . No Yes
5. Did the baby have any trouble while in the hospital? . . . . No Yes
6. Did you take any medications during pregnancy? . . . . No Yes
7. Circle any of the following diseases that this child's parents, grandparents, aunts, uncles, brothers or sisters have had:

Tuberculosis
Diabetes
Asthma
Cancer

Allergy
Seizures
Epilepsy

Nervous Breakdown
Inherited Diseases or Family Disease

8. Are the child's parents both in good health? . . . . Yes No

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9. Do any brothers and/or sisters have a health problem?	No	Yes
10. Have any of your children died?	No	Yes
11. Does your child feel good most of the time?	Yes	No
12. Does your child usually eat or drink the following daily?		
Vitamin D fortified milk.	Yes	No
Iodized salt.	Yes	No
Juices and fruit containing Vitamin C such as oranges, tomatoes, fruit drinks with added Vitamin C	Yes	No
Enriched bread and cereal products.	Yes	No
Protein foods such as meat, eggs, fish, cheese, dried beans, peanut butter.	Yes	No
Candy, pop, potato chips, pretzels, etc..	No	Yes
13. Has your child had as many as three bouts of ear trouble such as ear aches, draining ears?	No	Yes
14. Does he have apparent difficulty in hearing?	No	Yes
15. Does your child tend to have a stuffy nose or constant cold?	No	Yes
16. Does your child usually have more than three colds or throat infections with fever a year?	No	Yes
17. Has your child ever had wheezing or asthma?	No	Yes
18. Is your child able to keep up physically with other children?	Yes	No
19. Has your child had any trouble with his/her eyes or vision?	No	Yes
20. Has your child had any allergies or reactions to any food, medicines or injections?	No	Yes
21. Has your child ever had eczema or hives?	No	Yes
22. Does your child complain frequently of headache, leg ache, stomach ache, or other pain?	No	Yes
23. Does your child often have diarrhea?	No	Yes
24. Does your child have any trouble moving his bowels?	No	Yes
25. Has your child passed round worms or pinworms to your knowledge?	No	Yes
26. Does your child have any trouble passing urine?	No	Yes

27. Does your child chew unusual things such as pencils, cribs, window ledges, paint chips, plaster or hair? . . . . No Yes

28. Circle any of the following that your child has had:

"Red" or "Hard" Measles
German or "3-day" Measles
Scarlet Fever
Whooping Cough
Mumps
Chickenpox

Diabetes
Seizures
Epilepsy
Meningitis
Shortness of Breath
Heart Trouble

Pneumonia
Rheumatic Fever
Tonsillitis
Strep Infection
Ulcers (stomach)

Other illnesses or diseases? . . . . No Yes

If yes, what?____

29. Has your child ever been hospitalized? . . . . No Yes

If yes, for what?____________________________________

30. Has your child had any operations? . . . . No Yes

If yes, for what?____________________________________

31. Has your child had an(y) accident(s)?. . . . . No Yes

If yes, list injuries_________________________________

____

____

Any broken bones?. . . . . No Yes

If yes, list____

____

32. Has your child been under a physician's care in the past 12 months?. . . . . No Yes

If yes, for what?____________________________________

33. Does your child have to limit his activities for health reasons?. . . . . No Yes

If yes, in what way and why?__________________________

____

34. At what age did your child sit alone? . . . . __yrs.,__mos.

35. At what age did your child walk alone?. . . . . __yrs.,__mos.

36. Did your child say any words by 1½ yrs. of age? . . . . Yes No

37. Does your child have any trouble sleeping now?. . . . . No Yes

38. Are there any problems with his/her teeth? . . . . No Yes

39. Is your child taking any medicine now? . . . . No Yes

40. Does your child get along well with other children?. . . . Yes No

41. Circle any of the following which your child has or does:

Bites Nails
Sucks Thumb
Bad Temper
Nightmares
Irritable
Won't Mind
Wets Bed
Speech Problems
Jealousy
Can't Toilet Train
Breath Holding
Chews or Pulls Hair

*42. Has your child had a physical examination (regular check-up) in the past two years?

If so, where?

Date?

By whom?

*43. Has your child been through a medical screening program in the past two years?

If so, where?

Date?

*44. Has your child had a dental examination (regular check-up) or dental screen?

If so, where?

Date?

*added by EPSDT Day Care Project, 1978-79.

APPENDIX A7

Year II - Screening Information and Permission Forms for Parents

Dear Parent,

Our day care center has the opportunity (again this year) to take part in a City/University Project that we feel would be beneficial to our Center.

This project has as a goal to help day care centers further meet the individual needs of children, and to assist families or day care staff when outside resources are required for particular needs. Working to accomplish this will be a multidisciplinary team from education, nursing, and social work. A vital part of the team is the Community Coordinator who will serve as the project liaison to center staff and parents.

The Project will provide a health screening and developmental assessment. The health screening will be done at the Health Screening Center, 4133 Washtenaw, and the developmental assessment will be done at the day care center. There will be no cost to you or the center for this service. We will provide safe transportation for the children to the screening center. We do need your permission to provide these services.

An appointment will be scheduled during day care hours for your child to be screened. All possible effort will be made to accomodate parent's work or class schedule, but health regulations state that a parent must accompany their child during a health screening.

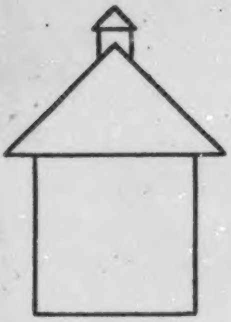
We will be having a meeting on Nov. 2, to explain the Project further and to give you a chance to ask questions. If you have questions about our Project and cannot attend the meeting, please ask your child's teacher, myself, or call the Project staff directly.

Please bring the attached permission form to our parent meeting.

Sincerely,

(Center Director)

PLAY DEVELOPMENT EDUCATION



October 27, 1977

Dear Parents,

The has been invited to participate in The City University Day Care Project.

The Project is funded by The Department of Health, Education and Welfare and last year served centers in Ann Arbor. This year the project received enough money to expand to the Ypsilanti area. Of the Ypsilanti centers, two were invited to participate. Ours was one of them.

After investigating the various aspects of the Project, the staff decided that participation in this project could provide many needed services to our children and staff.

The goals of the Project are:

1. to help us meet the individual needs of children.
2. to assist families and teachers in locating and using outside resources as they relate to specific needs.

The goals of the Project will be accomplished by using a multidisciplinary team approach. The team will consist of:

1. Our staff: Mary, Sue, Margo, Michelle, Robin and Mary Ann
2. A Community Co-ordinator: Ellen Kotlas
3. A Nurse: Lynn Clark, Marcia VanFossen
4. A Social Worker: Mimi Harris
5. An Educational Consultant: Babette Kronstadt

We (staff, children & parents) will have most of our direct contact with Ellen Kotlas, the Community Co-ordinator.

The Project will provide:

1. free health screening (at the Washtenaw Service Center).
2. free developmental assessments (DIAL) (here).
3. free follow up, to family and school, consultant services and in-service training.
4. free transportation to the health screening.

What is needed from parents?

1. Signed permission for your child to participate in the health screening and the DIAL assessment.
2. Two hours of your time to be with your child at the health screening (meet us there). This is required by law.
3. A health history (form to be provided later).

Health screening appointments will accomodate parents' schedules as much as possible.

Please complete the attached form and return it to a staff member.

We will be happy to discuss our participation in the Project with you and answer any questions you may have.

We are looking forward to working with you and the Project staff to better serve your children.

Sincerely,

(Center Director)

SCREENING INFORMATION

Attached is a permission form for your child to have a comprehensive health and developmental screening done at the Health Screening Center, 4133 Washtenaw.

The Health Screening Center has a blanket protocol that includes the following services:

1. Hearing screening - all ages.
2. Vision screening - all children over 3.
3. Denver Developmental screening - all children under age 6.
4. Height and weight.
5. Laboratory screening tests, i.e., a finger stick to screen for anemia, blood lead level, and sickle cell disease if indicated, and a urinalysis on each child to screen for diabetes and kidney disease.
6. Physical assessment that includes;
   a) blood pressure and heart rate
   b) examination of the skin and hair to note the presence of any rashes or scalp conditions.
   c) examination of the eyes, ears, nose, and throat, abdomen, extremities, and genitalia.

Any child screened must have the entire screening procedure.

Prior to the screening process, the parent will be requested to fill out a health history form and following the screening the nurse will give immediate feedback on screening tests and make indicated suggestions for further care.

Immunizations that are needed will be available to the child if the parent wishs the service. Immunizations provided are the DPT, (Diptheria, Pertussis, Tetanus), OPV Oral Polio Vaccine, and MMR. Measles, Mumps, and Rubella vaccine.

Also available if needed is a tuberculin skin test.. This involves placing a four-prong "button" on the child's forearm for a few seconds.

As part of the comprhensive screening but at a separate time, the project staff will administer the DIAL (Developmental Indicators for the Assessment of Learning), a developmental assessment often used by people in early childhood education.

In order to determine whether the activities of the City/University Day Care Project are having the intended effects, it will be necessary to analyze and report information collected on the children and all other persons who participate in this project. In reports on the effectiveness of this project no information will be revealed which would identify individual children, other participants or day care homes or centers.

Developmental Assessment (DIAL)

The DIAL(Developmental Indicators for the Assessment of Learning) provides a screening in four areas: gross motors, fine motor, concepts, communications.

The DIAL will be done in the center by a combination of center and project staff.

The parent need not be present for the screening.

Training for some of your staff members in administering 2 parts of the DIAL will be given in the project office.

The DIAL will be given in the center by a team composed of two project staff members and two center staff members. In addition, the Community Coordinator will act as coordinator of the DIAL. The DIAL and medical screening will be done as closely together as possible.

Feedback on the DIAL will be shared with staff and parents within 4-6 weeks. In addition, 8 individual comments on each child, profiles of total class performance will be shared with each caregiver. A decision to refer a child for further diagnoses will only be made after discussions with, and approval by the child's parents and caregivers.

10/19/77

CHILD'S NAME ______________________________

CENTER ___________________________________

In order to offer the City/University Day Care Project services to your child, we need your permission to:

Provide a comprehensive health screening, and in order to accurately record screening information, we need your permission to;

Look at your child's medical record at ____________________ Day Care Center.

Contact your child's physician, Dr. ______________________, if necessary.

Provide a developmental screening.

Use information gathered by the project on you child (in a non-identifying manner) in determining and reporting the effectiveness of this project.

Signed: ___________________________
(Parent or Guardian)

Address: ___________________________

Telephone: _________________________

Date: ______________________________

Note: In accordance with the Federal Freedom of Information Act, you have the right to access to the project's records on your child.

11/2/77

CITY/UNIVERSITY DAY CARE PROJECT
City Center Building
220 East Huron, Suite 220
Ann Arbor, Michigan 48104
Telephone: 764-8342

A7

Dear Parent,

We are beginning the scheduling of the health and developmental screening referred to in a recent letter from the director of your child's day care center. A health examination and developmental assessment will be available for all of the children at the center at no cost.

We remind you that a permission slip is necessary in order for your child to benefit from these services.

The health screening will take place on ________________ and the development assessment on ______________________.

Scheduling of appointments will be done by ________________, your center's community coordinator. She will make every effort to accomodate parent's and child's schedules.

Sincerely,

Ebba Hierta

Ebba Hierta
Associate Project Director

/tmp

Kindergarten Parents

The developmental screening for kindergarteners will include the Screening Test for Auditory Comprehension of Language (STACL) in addition to the DIAL. The STACL takes approximately five minutes and will be given by one of the people giving the DIAL. It was felt that although the DIAL should indicate if a child is having difficulties, the auditory comprehension screening will provide the teachers with additional useful information about the child's language comprehension skills.

If you have given permission for the developmental assessment, your child will participate in both screenings unless you request that only the DIAL or the STACL be given.

If you have any questions concerning this, talk to your child's teacher or feel free to call me.

Babette Kronstadt

Babette Kronstadt
Educator
City-University Day Care Project
764-8342

REPORT OF HEALTH SCREENING SUMMARY

Appendix A8

Date Screened ______________

NAME	BIRTH DATE	SEX	PARENT OR GUARDIAN
ADDRESS			PHONE - Home Work
PHYSICIAN'S NAME & ADDRESS			PHONE
DENTIST'S NAME & ADDRESS			PHONE

HEALTH HISTORY . . . . As reported by parents . . . .

A. IMMUNIZATIONS

IMMUNIZATIONS	Dates			Booster
Diphtheria				
Tetanus				
Pertussis				
Polio (Oral)				
Measles (Rubeola)				
Rubella				
Mumps				
Other				

B. TUBERCULIN TEST
Type: Date: Result:
____

C. Conditions which may require emergency care such as allergies, fainting, diabetes, seizures or other: ________
____
____
____

D. Health problems which need special attention or care: ______________
____
____
____

SCREENING TESTS	Within Normal Limits* Yes	No	Where Referred, Already Under Care, or Other
Hearing			
Vision			
Height (inches):			
Weight (pounds):			
Blood Pressure:			
Hematocrit (%):			
Sickle Cell			
Blood Lead			
Urine Sugar: Alb:			
Denver Developmental Screening Test			

(If delays, describe sector and recommendations) ______________________________

PHYSICAL INSPECTION			
General Appearance			
Cranium, Hair & Face			
Ears, Eyes & Nose			
Mouth & Teeth			
Skin			
Chest & Back			
Abdomen			
Muscle Tone			
Arms & Legs			

ADDITIONAL RELEVANT HEALTH INFORMATION

____
____
____

Date ______________ Signature ______________

Agency & Address ______________
____

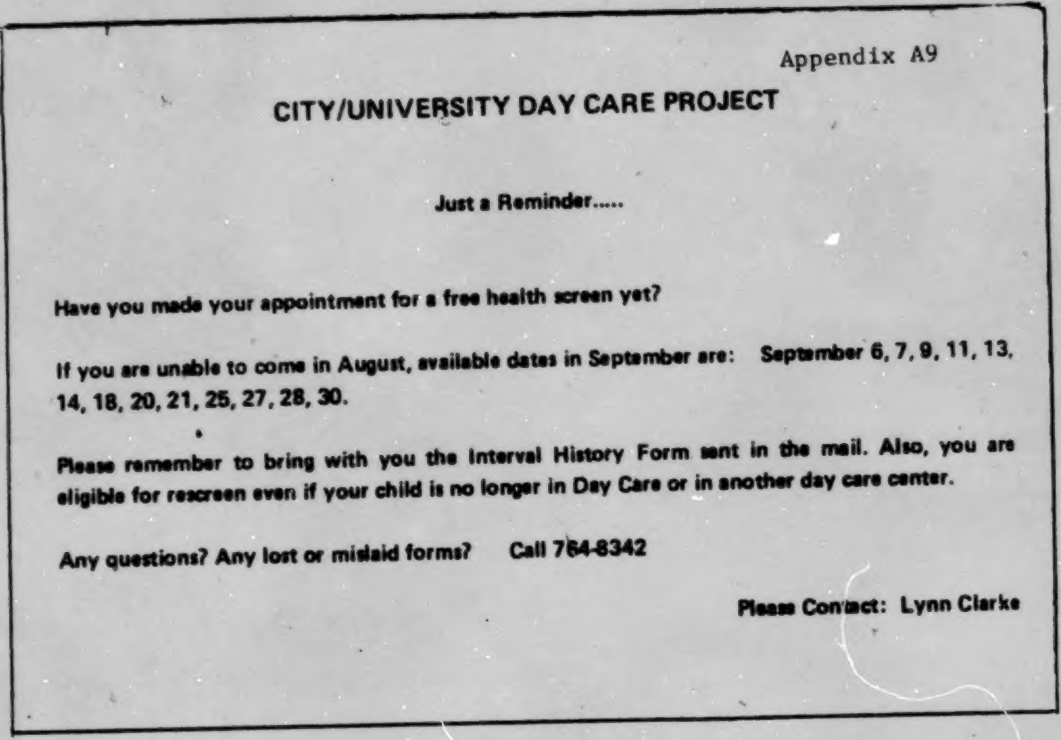
*MDPH-MCH/EPSDT Standards for Health Screening/1974

Form No. H-658a 12/76

APPENDIX A9

Year III - Health Screening

Information Packet for Parents



Appendix A9

CITY/UNIVERSITY DAY CARE PROJECT

Just a Reminder.....

Have you made your appointment for a free health screen yet?

If you are unable to come in August, available dates in September are: September 6, 7, 9, 11, 13, 14, 18, 20, 21, 25, 27, 28, 30.

Please remember to bring with you the Interval History Form sent in the mail. Also, you are eligible for rescreen even if your child is no longer in Day Care or in another day care center.

Any questions? Any lost or mislaid forms? Call 764-8342

Please Contact: Lynn Clarke

City/University Day Care Project

SUITE 220, CITY CENTER BUILDING
220 E. HURON ST.
ANN ARBOR, MICHIGAN 48104

TELEPHONE:
(313) 764-8342

Dear Parent,

Once again your center has agreed to participate in the City/University Day Care Project. The project is funded by the Department of Health, Education and Welfare and has served centers in Ann Arbor and Ypsilanti for the last two years.

One of our goals has been to offer preventive health care to children, and we have provided opportunity for free health screening to all children enrolled in the center. During the past year we have also provided educational workshops for center staff members.

As part of our continuing project, we are rescreening all the children screened in 1977 or January/February 1978. The health screening will be conducted at the Health Department Service Center, 4133 Washtenaw, and will be available in August and September. To accomodate your schedule, health screeening appointments will be made directly by parents.

This screening will be acceptable for entrance to day care, kindergarten, first grade, or after-school care. Should any health problems be detected, you will be referred to a qualified medical care person for further diagnosis and/or treatment.

Preventive health care is critical to helping young children achieve their best potential. We appreciate your assistance in helping to further this concept in day care.

We are enclosing:

1) Appointment instructions;
2) A permission slip to be signed as before, and returned in the envelope provided;
3) A letter of introduction to take with you to the clinic identifying you as a participating member of the City/University Day Care Project;
4) A short health-history update form you will also need to take with you; and
5) A map;

If you have any questions or concerns please call us at 764-8342.

Sincerely,

Lynn Clarke/Marcia Van Fosse

Lynn Clarke, PNP and Marcia VanFossen,
PNP,
Project Nurse Practitioners

LC/rw

CITY/UNIVERSITY DAY CARE PROJECT

HEALTH SCREENING INFORMATION

Attached is a permission form for your child to have a comprehensive health and developmental screening done at the Health Screening Center, 4133 Washtenaw.

The Health Screening Center has a blanket protocol that includes the following services:

1. Hearing screening - all ages.
2. Vision screening - all children over 3.
3. Denver Developmental screening - all children under age 6.
4. Height and weight.
5. Laboratory screening tests, i.e., a finger stick to screen for anemia, blood lead level, and sickle cell disease if indicated, and a urinalysis on each child to screen for diabetes and kidney disease.*
6. Physical assessment that includes;
   a) blood pressure and heart rate
   b) examination of the skin and hair to note the presence of any rashes or scalp conditions
   c) examination of the eyes, ears, nose, and throat, abdomen, extremities, and genitalia.

Any child screened must have the entire screening procedure.

Prior to the screening process, the parent will be requested to fill out a health history form and following the screening the nurse will give immediate feedback on screening tests and make indicated suggestions for further care.

Immunizations that are needed will be available to the child if the parent wishes the service. Immunizations provided are the DPT, (Diptheria, Pertussis, Tetanus), OPV Oral Polio Vaccine, and MMR, Measles, Mumps, and Rubella vaccine. First doses of DPT or Oral Polio can not be given, also, if your child is ill, immunizations will not be given.

Also available if needed is a tuberculin skin test. This involves placing a four-prong "button" on the child's forearm for a few seconds.

In order to determine whether the activities of the City/University Day Care Project are having the intended effects, it will be necessary to analyze and report information collected on the children and all other persons who participate in this project. In reports on the effectiveness of this project no information will be revealed which would identify individual children, other participants or day care homes or centers.

* If your child has been screened within nine months, the fingerprick and urine test portion of the screen will not be repeated.

CHILD'S NAME ______________________

CENTER ______________________

In order to offer the City/University Day Care Project services to your child, we need your permission to:

Provide a comprehensive health screening, and in order to accurately record screening information, we need your permission to:

Look at your child's medical record at ______________________ Day Care Center;

Contact your child's physician, Dr.______________________, if necessary;

Use information gathered by the Project (in a manner that will not identify your child) in determining and reporting the effectiveness of this Project.

Signed: ______________________
(Parent or Guardian)

Address: ______________________

City, Zip: ______________________

Telephone: ______________________

Date: ______________________

Note: In accordance with the Federal Freedom of Information Act, you have the right of access to the Project's records on your child.

Date of health screening appointment: ______________________

7/20/78

CITY/UNIVERSITY DAY CARE PROJECT

APPOINTMENT INSTRUCTIONS

Parents must make an appointment before a clinic visit. This clinic does not accept walk-in appointments. The number to call for a health screening appointment is:

994-2951

When you call, identify yourself as a member of the City/University Day Care Project.

Available appointment days for August are: August 2, 3, 5, 7, 9, 10, 14, 16, 17, 21, 23, 24, 26, 28, 30, and 31. The clinic is open 8:30 a.m.-12 noon and 1-5 p.m. Saturdays, the clinic is open 8-12 noon. In general, the clinic is open Monday, Wednesday, Thursdays and the first and fourth Saturday of each month.

Please write in your appointment date on the enclosed permission slip.

City/University Day Care Project

SUITE 220. CITY CENTER BUILDING
220 E. HURON ST.
ANN ARBOR, MICHIGAN 48104

TELEPHONE:
(313) 764-8342

July 19, 1978

To EPSDT Staff:

This letter is to introduce you to one of the families participating in the City-University Day Care Project.

Please give parents a copy of the 'Report of Health Screening Summary', Form No. H-658a, when the screening is completed.

In case any follow up of the screening is necessary, please contact Lynn Clarke or Marcia VanFossen at the City/University Project, 764-8342.

Thank you.

Sincerely,

Lynn Clarke, PNP

Marcia VanFossen, PNP

LCMVF/gd

WELCOME
to the
Washtenaw County EPSDT Health Screening Clinic

The EPSDT stands for Early, Periodic, Screening, Diagnosis, and Treatment and is intended to provide health care early in life and periodically thereafter. The program is conducted in cooperation with the Division of Social Services.

Upon your arrival, the receptionist will need your Medicaid card and the history forms you have filled out in order to make up a folder for you.

The screening tests that will be given are:

1. Hearing screening - all ages.
2. Vision screening for all over three (3) years of age.
3. Denver Developmental screening tests (for children under six (6) years of age) - A test that helps to determine how your child is developing.

In the above tests, school age children may have the screening without the parent present in each step of the program. For the child under six (6), it is necessary for the parent to accompany the child throughout the total screening. Parents are welcome to accompany all age children throughout the screening should they so desire.

After the Hearing, Vision, and Denver Developmental screening the following lab tests are given:

1. A urine specimen is tested. The children or young adults are asked to leave a specimen in the bathroom in a paper cup that is provided. If your youngster needs to go to the bathroom before he is called into the lab, please let the receptionist know so that a specimen can be obtained.

2. Blood tests for anemia - all ages.
   Blood test for amount of lead level for children under six (6).
   Sickle Cell test

3. While in the lab, they will also be weighed and measured.

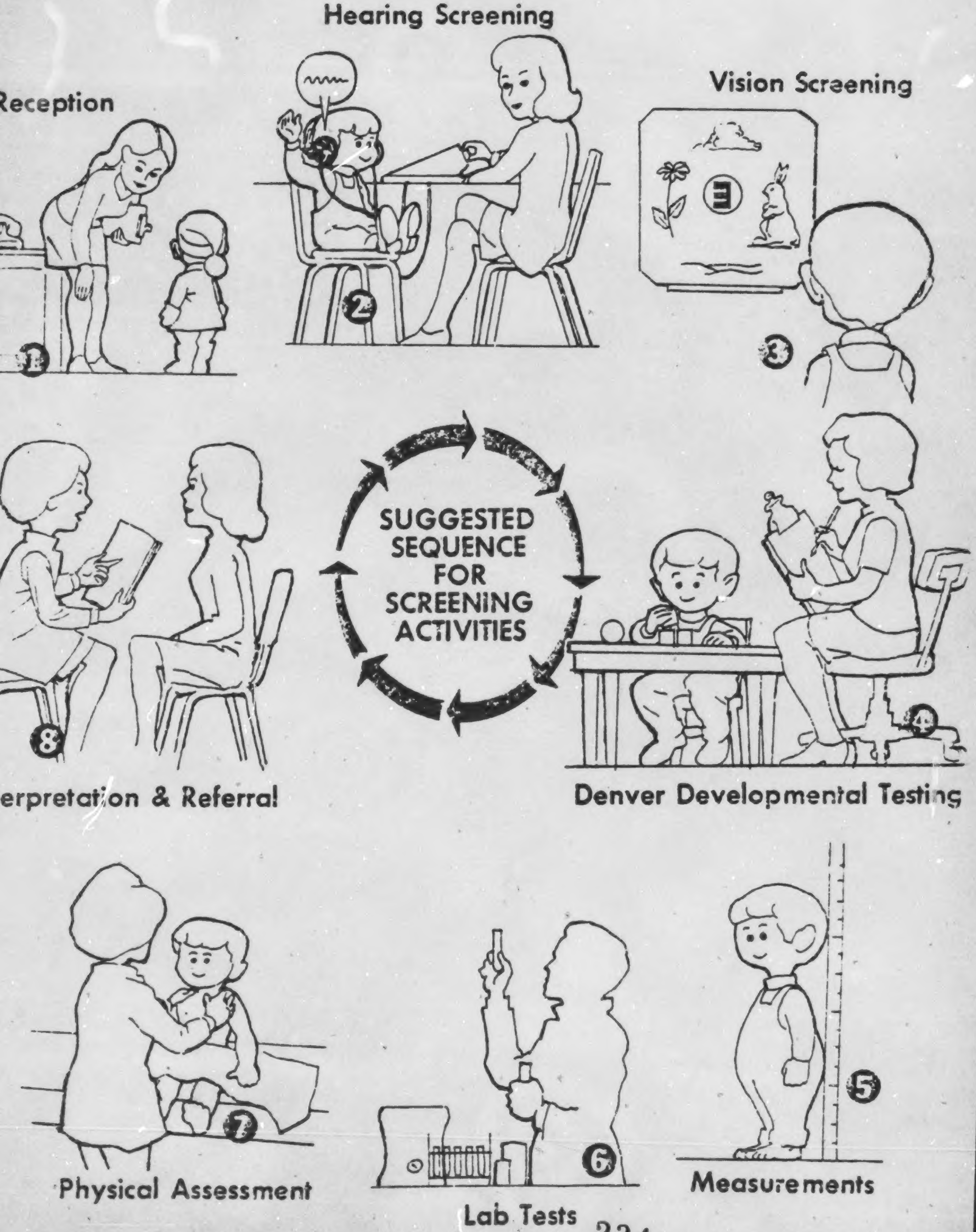
The next step in the screening process is a physical assessment by the nurse.

After the nurse has seen the child or young adult, she will talk with the parent to discuss the findings of the screening tests and assist in making referrals to physicians or dentists, or other clinics if indicated.

If at any time while you are here you have questions or need assistance, our staff will be happy to help!

There are toys, books, and games for the children - magazines, pamphlets, and reading materials for the adults. We ask that you be responsible for your personal belongings while in the clinic.

We hope your visit is a pleasant one.


Hearing Screening
Vision Screening
Reception
1
2
3
SUGGESTED SEQUENCE FOR SCREENING ACTIVITIES
8
4
erpretation & Referral
Denver Developmental Testing
7
6
5
Physical Assessment
Lab Tests
Measurements

TANDARDS OF DENTAL CARE

uggested schedule for preventive child dental health care*

Age	Developmental landmarks	Discussion and guidance	Procedures
renatal period		Parent education to dental needs Effect of drugs on developing dentition during pregnancy Diet and proper dental habit	Brochures and pamphlets from American Dental Association; fluoridated drinking water
ewborn	Edentulous gumpads Infantile swallowing pattern	Parent education to dental needs Effect of drugs on developing dentition during pregnancy Diet and proper dental habit Congenital anomalies Birth trauma	Thorough oral examination by obstetrician, pediatrician, etc.
irth to 6 months	Neonatal teeth Lower deciduous incisor eruption Epstein pearls	Parent education to dental needs Effect of drugs on developing dentition during pregnancy Diet and proper dental habit Congenital anomalies Dental arch and dentitional development	Fluoridated drinking water
to 30 months	Correct eruption sequence and time of eruption Completion of deciduous dentition Transitional period from infantile to mature swallow Tongue, lip, finger habits Learning and sleeping habits	Effect of drugs on developing dentition during pregnancy Diet and proper dental habit Dental arch and dentitional development Traumatic injuries Oral habit patterns	Oral hygiene Oral habit control. Dietary regimen check
0 months to 6 years	Complete deciduous dentition Appearance of spaces between incisor teeth	Period of use of complete deciduous dentition and developmental preparation for permanent teeth Routine periodic visits to the dentist Oral manifestations of medication and drug therapy Traumatic injuries more likely Temporomandibular joint disturbances (bruxism, clenching, rheumatoid arthritis, etc.) Dietary regimen	First visit to dentist Supervision of dental occlusion and development (arch and jaw relationships and space control) Control of abnormal pressure habits Caries control procedures Oral hygiene instruction
to 12 years	Mixed dentition period Eruption of eight permanent incisors and four permanent molars by 8½ years Loss of deciduous molars, eruption of premolars by 10½ to 12 years	Periodic dental visits (at least twice a year) Caries, soft tissue problems Malocclusion Oral manifestations of medication and drug therapy Traumatic injuries more likely	Supervision of dental development (arch and jaw relationships and space control) Optimal time for orthodontic consultation and guidance; possible interceptive procedures Oral hygiene instruction

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*oint statement prepared by a committee of representatives from the American Academy of Pedodontics, The American Society of Dentistry for hildren, the American Association of Orthodontists, and the American Academy of Pediatrics, September, 1966. From Standards of child health re, Evanston, Ill., 1967, American Academy of Pediatrics p. 115.

rage age most dentists prefer for a first visit is 3 1/2 years. If caries
apparent child should see a dentist regardless of age.

STANDARDS OF DENTAL CARE—cont'd
Suggested schedule for preventive child health care

Age	Developmental landmarks	Discussion and guidance	Procedures
6 to 12 years —cont'd	Eruption of second molars (12 year molars)	Temporomandibular joint disturbances (bruxism, clenching, rheumatoid arthritis, etc.) Dietary regimen Oral effects of endocrine activity	Caries control Soft tissue care
12 to 19 years	Completion of permanent dentition Possible third molar eruption (girls first)	Periodic dental visits (at least twice a year) Caries, soft tissue problems Malocclusion Oral manifestations of medication and drug therapy Traumatic injuries more likely Temporomandibular joint disturbances (bruxism, clenching, rheumatoid arthritis, etc.) Dietary regimen Oral effects of endocrine activity	Supervision of dental development (arch and jaw relationships and space control) Optimal time for orthodontic consultation and guidance; possible interceptive procedures Oral hygiene instruction Caries control Soft tissue care Active orthodontic therapy Replacement of missing teeth Esthetic and functional considerations

DENTAL RESOURCES IN ANN ARBOR

City/University Day Care Project

Model Cities Dental Clinic 761-2176
704 Spring Street
Ann Arbor, Michigan

Hours: Monday, Tuesday, Friday - 9:00 a.m. to 5:00 p.m.
Wednesday, Thursday - 9:00 a.m. to 9:00 p.m.
Saturday, 9:00 a.m. to 12:00 p.m.

Fee: Medicaid coverage is accepted. For emergencies, if there is no Medicaid coverage the fee is $12.00 if a resident of the Model Cities area. If not a resident, there is a $15.00 fee for emergencies.

Services: Only routine dental work. Except for emergencies, only residents of Model Cities area are served.

Must bring in proof of income and address, in person, before the first appointment is made.

Children's Dental Clinic 663-7074
Mack School
920 Miller
Ann Arbor, Michigan

Hours: Irregular. By appointment only. (Average 4-5 half days per week.) Not open during summer or school vacations.

Fee: Nominal. Financial qualifications: Do not accept Medicaid. Available to children with no other resources, and not able to afford private dental care. Applications filled out and reviewed. Appointments made afterwards.

Age: Children from kindergarden thru 12th grade.

Services: Dental examination and restorations, prophylaxis and fluoride treatments.

Operated by Women's Auxillary to the Washtenaw District Dental Society.

School of Dentistry 764-1516 (General Information)
University of Michigan

Hours: 9:00 a.m. - 12:00 p.m., 1:00 - 5:00 p.m., everday, except Wednesday, with some exceptions.

Fee: Reasonable fees are charged. These are payable when treatment is begun. Dental Insurance is honored.

Services: All services avaliable. Several month waiting list, except in Dental Hygiene Clinic.

If immediate treatment needed, call clinic; place name on waiting list; see private dentist and then continue with school.

All work is done by students who are carefully supervised by instructors. Work does take longer than most regular appointments.

Adult Clinic 764-1516

See above information

Children Clinic 764-1523

All services 4 to 6 month waiting list. No emergencies. Parents to accompany children.

Dental Hygiene Clinic 764-1544

Fee: Nominal. Children under 10 are charged reduced fee.

Hours: Vary. Complete cleaning, requires at least a two hour appointment.

Open September through April.

Children under 10 years must be accompanied by a parent.

Washtenaw District Dental Society 761-4085
625 East Liberty
Ann Arbor, Michigan

This is strictly a referral agency. They will supply names of appropriate dentist, and also names of dentists who accept Medicaid patients. Families on Medicaid may also contact their DSS worker who may suggest dentists who accept Medicaid eligible patients.

University Mott Dental Clinic 763-2421

Hours: Appointments on part time basis.

Fee: Accept Medicaid, Cripple Children payment.
Fees on request.

Qualifications: See children private dentist have difficulty caring for in private office, (i.e., children with mental and physical handicaps.

3/18/73

A SNACKING GUIDE MORE OR LESS:

APPENDIX A10

	MORE OF THESE	LESS OF THESE
DAIRY GROUP	milk, cheese (Swiss, Cheddar, cream, cottage), plain yogurt	chocolate milk, ice cream, ice milk, milk shake, fruited yogurt
MEAT GROUP	lunch meats and hot dogs (without added sugar), nuts, eggs (esp. hard boiled), chicken, ham & egg salads, peanut butter	meats with sugared glazes, peanut butter (with added sugar), lunch meats & hot dogs (with added sugar)
FRUIT AND VEGETABLE GROUP	**Fruits:** (fresh and/or packed in water or juice) oranges, grapefruits, tangerines, apricots, plums, apples, pears, peaches, nectarines, cherries, strawberries, grapes, melons, avocados, pineapples, olives	dried fruits (figs, raisins, prunes), fruits packed in syrups, jam, jelly, fruit preserves
	Vegetables: salad greens, cauliflower, cucumbers, green peppers, tomatoes, radishes, carrots, celery	candied sweet potatoes, glazed carrots
	Fruit & Vegetable Juices: (unsweetened) orange, apple, grape, grapefruit, tomato	sweetened fruit drinks
BREAD & CEREAL GROUP	popcorn, soda crackers, toast, hard rolls, pretzels, potato chips, corn chips, pizza	cookies, sweet rolls, pie, cake (esp. with frosting)
OTHER	sugarless gum, sugar free soft drinks, coffee or tea (without added sugar)	coffee & tea with added sugar, soft drinks with added sugar, candy, fudge, caramels, honey, sugars and syrups

* Food considered safe for oral health are not necessarily nutritious.

American Dental Association
211 East Chicago Avenue
Chicago, Illinois 60611

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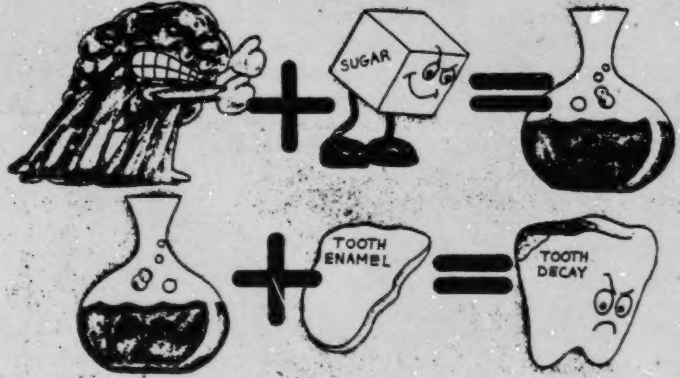
KICK THE SWEET SNACK HABIT

Snacking on sweets is one of the worst things you can do to your teeth. Bacteria in your mouth use sugar to produce acids which attack the enamel on your teeth.



If you avoid the foods which "trigger" the decay-producing acid you eliminate a cause of tooth decay. Use the following snacking list as a guide to the "right kinds" of snacks to promote good oral health.

City/University Day Care Project

SUITE 220. CITY CENTER BUILDING
220 E. HURON ST.
ANN ARBOR, MICHIGAN 48104

TELEPHONE:
(313) 764-8342

Dear Parents,

Recently the children at ______________________________ were screened by the U. of M. Community Dental Health Mobile Unit, regarding apparent dental needs.

We learned that your child has:

_____1. No observable decay

_____2. Slight amount of tooth decay (1 to 2 cavities)

_____3. Moderate amount of tooth decay (more than 2 cavities)

_____4. Serious decay that warrants immediate attention before damage to permanent teeth occurs.

Please note that a radiographic (X-Ray) examination was not performed.

If 2, 3, or 4 are checked, we recommend that you make a follow-up visit to a dentist.

If you have any questions, please call us.

Sincerely,

D. Lynn Clarke/tmp

D. Lynn Clarke, PNP

Marcia T. Van Fossen

Marcia T. Van Fossen, PNP

/tmp
11/30/78

City/University Day Care Project

SUITE 220, CITY CENTER BUILDING
220 E. HURON ST.
ANN ARBOR, MICHIGAN 48104

TELEPHONE:
(313) 764-8342

INDIVIDUAL DIAL PROFILE

Child's Name: ________________ Center: ____________________________

We are pleased to share the results of the DIAL screening with you. This developmental assessment measures four areas of skill: gross motor, fine motor, concepts and communications. The results of your child's screening will be shared with his/her teacher to facilitate educational programming in the classroom. In addition, children whose scores in these skills fall below the DIAL cut-off point for their age will be identified for help in areas of need. The DIAL, however, because of the nature of screening, cannot provide an in-depth evaluation of your child's development.

If the items on the list below are checked, it indicates a need for help in that area:

		Examples
______	Gross Motor	- Throwing, jumping, standing still
______	Fine Motor	- Copying letters, building, matching shapes
______	Concepts	- Naming colors, counting, understanding prepositions
______	Communications	- Remembering, telling a story, naming nouns and verbs

The DIAL was designed for use with pre-school children between the ages of 2 1/2 and 5 1/2. From our experience during its use in the pilot phase of our project, however, the results for children between the ages of 3 and 5 seem to be most reliable.

Comments:____

____

____

____

____

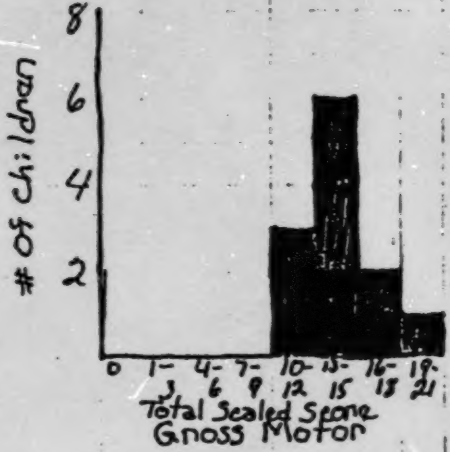
____

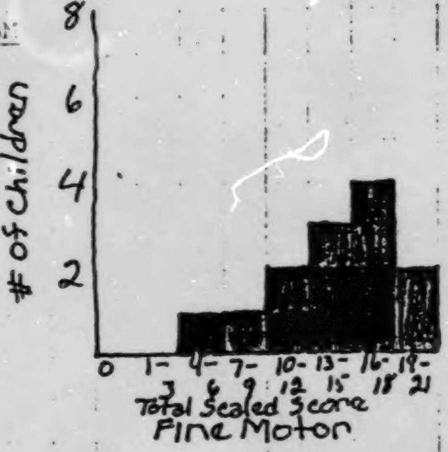
____

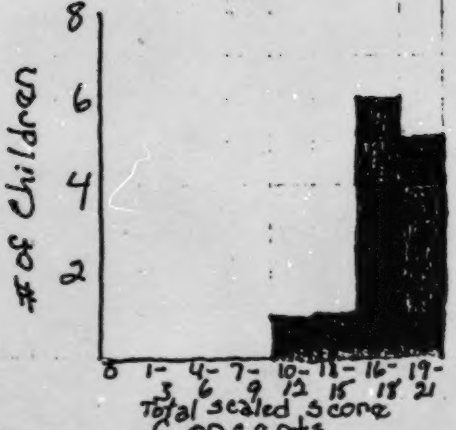
Within the next few months, you will receive a copy of our new parent activity book, Big Hands, Little Hands Together. The suggested activities will help build skills for your child. We hope that you and your youngster will enjoy them together.

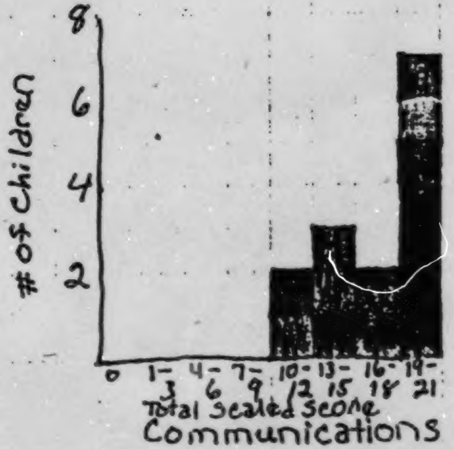
APPENDIX A 12

DIAL HISTOGRAM









Key
- ▨ dialed la
- ▨ 2.6-3.5 ye
- ▨ 3.6-4.5
- ▨ 4.6-5.5

Dial Scores - Nursey and Kdg. - Gold Room

Appendix A13

City/University Day Care Project

Suite 220, City Center Building
220 E. Huron St.
Ann Arbor, Michigan 48104

Telephone:
(313) 764-8342

(Cover Letter for DIAL Profile)

Dear ______________________________,

Your child ________________________________ has recently participated in a developmental assessment at ______________________________. His/her development was assessed in four areas: gross motor, fine motor, concepts and communication.

A form is enclosed which will indicate to you what we were able to learn about your child's development in these four areas. A copy of this form has been given to your child's caregiver. As indicated on the original permission form, these records are confidential and will not be shared with anyone else unless you request it.

It is important to remember that much of a child's growth takes place through active involvement in ordinary activities. We need also to remember that growth is constantly occurring even if it is not readily apparent and that a child's future skills will build upon those that (s)he has already acquired. Growth rates in children vary widely. Therefore, we do not look at children in order to compare them but in order to learn where an individual child is developmentally. We can then know what kinds of activities will encourage his/her future growth.

In a few months you will receive a copy of Big Hands, Little Hands Together. This booklet contains suggested activities you may wish to use with your child at home.

We hope your child's participation in the assessment was interesting and fun for him or her. If you have any questions or concerns please don't hesitate to get in touch with us.

PREPARING THE WORKSHOP ON GROSS MOTOR DEVELOPMENT

Workshop Objectives

1. To discuss the relationship between gross motor and other areas of development (e.g., self concept, language).
2. To explain the developmental sequence of gross motor skills and the importance of being aware of the child's developmental level in gross motor skills.
3. To describe the most common orthopedic problems in young children.
4. To provide caregivers with activities for different gross motor developmental levels.
5. To discuss gross motor activities that should be avoided with young children.
6. To show examples of inexpensive equipment that can add variety to gross motor activities.
7. To encourage caregivers to use a variety of approaches in presenting movement activities.
8. To provide sources of free and inexpensive materials to use for gross motor equipment.
9. To provide instructions for making inexpensive gross motor equipment.

CITY/UNIVERSITY DAY CARE PROJECT.

Workshop Participants Questionnaire.

Date ______________

Title ______________

Center ______________

Please mark ONE of the statements, for EVERY question.

entation

1. The workshop was well-organized.

strongly disagree	disagree	agree	strongly agree

2. The manner of presentation was appropriate to the topic of the workshop.

strongly disagree	disagree	agree	strongly agree

3. The content presented covered the topic adequately, for my needs.

strongly disagree	disagree	agree	strongly agree

ledge

4. How much did the workshop increase your basic knowledge of the topic?

not at all	a little	a moderate amount	a lot

rvation

5. How much did the workshop help you in thinking of practical ideas for recognizing and understanding specific behaviors and problems?

not at all	a little	a moderate amount	a lot

ram
ning

6. How much did the workshop help you in thinking of practical ideas for matching activities to the individual child's abilities, needs or interests?

not at all	a little	a moderate amount	a lot

7. How much did the workshop help you in thinking of practical ideas for organizing ideas and materials for program activities?

not at all	a little	a moderate amount	a lot

raction

8. How much did the workshop help you in thinking of practical ideas for interacting with the child during program activities?

not at all	a little	a moderate amount	a lot

9. How much did the workshop help you in thinking of practical ideas for building rapport and communication with children &/or adults?

not at all	a little	a moderate amount	a lot

unity
urces

10. How much did the workshop help you in thinking of practical ideas for finding information and materials that can be used by the center?

not at all	a little	a moderate amount	a lot

11. How much did the workshop help you in thinking of practical ideas for assisting families to find sources of help in the community?

not at all	a little	a moderate amount	a lot

rd-
eping

12. How much did the workshop help you in thinking of practical ideas for developing and/or using a record-keeping system to chart progress, or to plan for a child?

not at all	a little	a moderate amount	a lot

1/22/79.

OVER . . . .

13. What did you find most valuable about the workshop?

14. What did you find least valuable about the workshop?

15. What would you like as a follow-up to this workshop?

16. What changes are you likely to make, or to suggest, as a result of what you have learned in the workshop?

Add any other comments you would like to make.

City/University Day Care Project

FAMILY DAY CARE HOMES: OBSERVATION CHECKLIST

Code #

BACKGROUND DATA

1) No. of years operating a Day Care Home ______

2) Reasons for operating a Day Care Home ______________________________

____

3) Date joined Project __________

4) Reasons for joining the Project ______________________________

____

5) Related Employment history ______________________________

____

6) Related Education (formal & informal) ______________________________

____

7) Age of FDCM 21-30/ 31-40/ 41-50/ over 50

8) Children in FDCM's own family:
youngest is pre-school age/
youngest is school age/
no children at home/ adult children

9) Husband's Occupation:
no husband/ blue collar worker/
white collar worker/ welfare recipient

FAMILY DAY CARE HOME

10) Type of home: apartment/duplex/house/other ____________

11) Location: urban/suburban/rural/other ____________

12) Has the FDCM obtained additional furniture or equipment (e.g., cribs, toys), or made replacements in the home? ______________________________

____

13) Does she have use of a car? Yes/ Sometimes/ No

14) Is Public Transport accessible? Yes/ Sometimes/ No

15) Most accessible Day Care Center (name) ______________________________

16) Most accessible Day Care Home (name) ______________________________

17) FDCM has made contacts with Day Care Homes & Centers Yes/ No

Name ____

18) Are facilities/resources for preschoolers accessible? Yes/ No

Library ________

Park/playground ________

Hospital/health facility ________

Other ________

	not at all	a little	a moderate amount	a lot
19) The amount of space used for day care children is adequate				

20) What noticeable safety hazards are in the home? ______________________

____

21) What kinds of records does the FDCM keep re: FDC children? ________

____

22) The FDCM sees her role as: (rank in order)

____ teacher
____ substitute mother
____ babysitter
____ other ________

	not at all	a little	a moderate amount	a lot
23) The FDCM has an accepting attitude towards the children				
24) The FDCM has a co-operative attitude towards the parents				
25) The FDCM is interested in receiving further training in early childhood care				

26)	No. in day care	what days attending	what hours attending	which are not acceptable to FDCM
infants (to 18 months)	____	________	____to____	______
toddlers (1/2 to 3 yrs)	____	________	____to____	______
pre-school children	____	________	____to____	______
after-school children	____	________	____to____	______
*physical problem	____	________	____to____	______
*emotional problem	____	________	____to____	______
*developmental delay	____	________	____to____	______
child from different cultural/ethnic background of FDC Home	____	________	____to____	______

*Evaluation:

By whom*______________ Date ____________

*______________ Date ____________

*______________ Date ____________

27) No. of children in FDC Home, related to FDCM ____________

28) Any observed differences in treatment, by the FDCM, for related and unrelated children ____

____

29) Others helping in the FDC operation (hours/week): Family adults ______/
family children ______/ parents of day care children ______/
Others ______________

30) Is there a readily available substitute caregiver? ____________________

31) FDCM Time Allocation: (approx. Hours/day)

individual activities with children ________________

group activities with children ________________

day care related activities ________________
(e.g., meal preparation, washroom help)

Meals and Snacks

32) When served a.m. ____________________

p.m. ____________________

33) No. of children who bring lunch ________

34) No. of children for whom lunch is provided ________

35) Do children assist in the preparation of snacks or meals? __________

36) Are meals and snacks nutritional?	not at all	a little	a moderate amount	a lot

Rest Time

37) Where do children rest? ______________________________

	not at all	a little	a moderate amount	a lot
38) Are children supervised during rest time?				
39) Does the amount of rest meet the children's needs?				

40) What are the Parents' sources of health care for the children?
physician/ clinic/ hospital/ Health Dept./ none/ D.K./ other ________

41) Parents: No. single parent home __________

No. both parent home __________

42) Reasons for using Family Day Care ______________________________

____

43) Why this Family Day Care Home? ______________________________

____

44) FDCM Interaction with Parents

	Do Parents request information?	Does FDCM provide information	offer advice
activities of child in FDC Home			
child's life at own home			
needs of child			
scheduling, payment			
parent's personal needs			

Other interactions. ______________________________

45) When could the FDCM find it necessary to call a Parent? ____________

____

46) What is the extent to which the FDCM understands the different needs of children at different developmental stages?

	not at all	a little	a moderate amount	a lot
health				
nutrition				
gross motor				
fine motor				
cognitive				
communication				
social/emotional				

47) To what extent does the FDCM understand parent's needs?				

48) Activities

	Does each occur (yes/no)	Amount of time (rank)	To what extent is the activity used productively?			
			not at all	a little	a moderate amount	a lot
Structured play gross motor fine motor concepts						
Reading or story-telling to children						
Music with children						
Use. T.V.,e.g., Sesame St.						
Allow free time						
Field trips						

Other

	not at all	a little	a moderate amount	a lot
49) Responds to children in ways to make them feel secure and cared for				

50) Activities:

adult doing the activity, with child looking on				
adult telling child what to do				
adult helping child				
child initiating own activity				
child helping child				

51) FDCM guides children's behavior by:	not at all	a little	a moderate amount	a lot
praise				
criticism				
explanation				
discussion of feelings				
redirection				

52) What Community Resources does the FDCM:

	* Know of	* Use		* How useful does she find each service?			
		for FDC child/family	for self or family	not at all	a little	a moderate amount	a lot
Health Care							
Counselling							
Educational							
Other							

COMPILED RESULTS FROM FAMILY DAY CARE CHECKLIST

Background Data of the 8 Family Day Care Mothers in the City/University EPSDT-Day Care Project:

The Family Day Care (FDC) mothers have been operating day care homes over a range from 3 to 11 years, with a mean of 4½ years and a mode of 5 years.

The FDC mothers gave different reasons for operating a day care home, including: enjoying work with young children (5); own grandchildren (2); own children (4); needed day care services (1); and needed the benefit of extra income (6).

The FDC mothers' have been with the Project for a range of 3 months to 2½ years, with 6 having joined the Project its third year of operation.

The FDC mothers gave various reasons for joining the Project. Most mothers were initially contacted by the Project and then joined (see previous section). One mother originally heard from the parent of one of her day care children about the Project' and another had worked with the Project while a teacher in a day care center. Both of these latter FDC mothers were invited by the FDC coordinator to join the Project.

The particular reasons for belonging to the Project centered on the training and consultation functions, namely, wanting to attend workshops (6), needing materials (1), wanting help in finding medical resources (2) and general consultation (1).

The most common related employment of the FDC mothers was as parents themselves. One mother is currently a Sunday School Teacher, and another has worked as a day care center teacher.

The educational background of the FDC mothers is diverse: a minimum of high school education, and a variety of informal training such as on-the-job training as a teacher's aide (2); attending conferences on day care (3); attending workshops, (both Project and elsewhere) (5); and their own self-directed reading (7). Two FDC mothers are attending classes in early childhood education (college and/or university) and one has an associate degree in early childhood.

The FDC mothers are most commonly middle-aged, ranging between 31-40 (3 mothers), 41-50 (4), and one is over 50. Most typically the FDC mothers have school-aged children in their own family, with a pre-school aged child, and 2 with children who have left school. Four homes have grandchildren living in, as part of the extended family.

Three husbands are licensed as family day care parents. The most frequent employment of the husbands is in industry (4 men) and 2 are "white collar". Two mothers do not have husbands. This should be interpreted in the light of the Project's goal of contacting homes that cater to low income families.

Family Day Care Home Descriptions

The Homes themselves are mostly single houses (7), and one (1) duplex. All are suburban parts of the district reached by the Project. All FDC Homes have obtained additional goods to aid in their day care function. (e.g., cribs, beds and bedding, toys and books) and some adjustments to home (e.g., gates and fences).

Most FDC mothers have available transportation: 7 have the use of a car, 1 has use "sometimes"; public transport is accessible to all. There are day care centers in close proximity to 5 homes, although the other day care facilities are not in the Project. Actual contact is made with nearby day care facilities by 5 of the day care mothers. The establishment of a connection between FDC Homes and day care centers is a major goal of the Project.

Resources for preschoolers are accessible to all FDC Homes. Those that can be used are: library; including Bookmobile (4 Homes); park/playground (8); hospital/health facility (7); and public school (5).

The amount of space for care of children in FDC Homes seems to be adequate for the number of children in each home. The FDC mothers are aware of danger that could occur in the home and have taken care of all noticeable safety hazards in their homes.

Recordkeeping in each Home was done in the way each FDC mother felt was useful to her. Recordkeeping was not done by all FDC mothers in all areas. DSS records were done by all; food records (2); spending for supplies (1); health (1), fee payments (1) and personal records for each child (1).

The FDC mothers see themselves as combined teacher and substitute mother; rarely would they consider babysitting as even a minor role. The FDC mothers show a moderate to high accepting attitude towards children in their care; their attitude towards parents is moderately cooperative differing with the individual FDC mother and particular parents). They have a moderate to high interest in receiving training in FDC. The FDC mothers seemed to treat all children equally with lots of love and were all very warm to the children, no matter if they were her grandchildren or not.

The children in the care of FDC mothers range in age from infants to school-aged children, with pre-schoolers representing the largest number. The total number of children in FDC Homes participating in the Project, is 42. The number in a single Home varies from 2 to 10. FDC Homes officially operate on weekdays, but all of the FDC mothers have on some occasion taken children on the emergency basis on a Saturday or Sunday. The hours of operation vary, but usually extend from before-school hours (6:30 a.m. is the earliest) to after-work hours (the lastest is 1 a.m.!).

Assistance to the FDC mothers varied. Four had their own children's help after school, and had the help of adults in the family, and one had no help at all.

Substitutes were used rarely and when they were, they were usually members of the family. Two (2) used outside people who were friends and had exchanged services.

All activities with individual children are not planned daily by the FDC mother. They are usually done spontaneously when the FDC mother feels it is a good time or is needed. Group activities with the children are done on an average of 2 hours weekly in each home.

Meals and snacks are served daily in each home. Snacks are served when a child is in the home more than 5 hours. Lunch is served to all children (35) that are in the home during the hours between 12:00 p.m. and 1:30 p.m. This is consistent in all eight FDC Homes that are in the Project. No children bring lunch from home. All family day care mothers at times let children assist in the preparation of snacks and meals. The FDC coordinator observed that in her presence meals and snacks that were served were nutritional and the children enjoyed them.

Areas in the Homes that are used for rest are bedrooms and family rooms where mattresses, playpens and cribs are placed. A moderate amount of supervision is done by FDC mothers during rest time. The amount of rest needed by the individual children differs but each FDC mother seemed to see that each child's needs for rest is met.

Sources of health care used by parents for their children vary: physician (6), hospital (5), clinic, (2), health department (1). Some parents may use up to three different services.

Single parents using the FDC Homes totaled twelve. Five children came from families with both parents present. Three FDC mothers refused to give information on the status of their parents.

Parents' reasons for using FDC were: working parents; parents are students; mother needs time alone; and children needed the experience of being with other children in a small setting (FDC mother was the grandparent). Fee location and time of operation was the main reason for choosing most FDC homes.

Information about activites and interaction of the child in the FDC Home was routinely given to parents at the end of the day in a few homes. Such information was given to the parents on request, in all of the homes. All eight FDC mothers call a parent when they feel that it is needed. If there is an emergency health problem, all will call parents immediately.

CITY / UNIVERSITY DAY CARE PROJECT.

FAMILY DAY CARE INTERACTION LOG

DATE	TIME (beg.& end)	PLACE	CONTENT (Initial or Follow-up) (Purpose, Activity, Materials)	PROJECT STAFF or OUTSIDE CONSULTANT PARTICIPATING	COMMENTS

Appendix A17

3/27

Appendix A19

APPENDIX A18

The Children's Yellow Pages

REPORT
# of the
WASHTENAW COUNTY INTERAGENCY COMMITTEE

For six months since September, 1978 representatives from the Child Care Coordinating and Referral Service, Washtenaw County Department of Social Services, Washtenaw County Health Department, Washtenaw County Community Mental Health, Washtenaw Intermediate School District, and the City University Day Care Project have met at three week intervals around coordination of services to young children and their families in Washtenaw County. The focus of this interagency committee has been to examine issues and develop recommendations with regard to the needs of young children and their families as well as the service delivery systems designed to meet the needs of these young families. (See Appendices A and B.)

The following report, in outline form, provides an overview of the committee process and accomplishments, and includes both short and long-term recommendations toward increased coordination of service between Washtenaw County agencies.

I. Assessment Phase - Initial focus on developing a common base of understanding and identifying concerns.

A. Concerns:

- How do we find "children and their families who are having problems and as yet have not come into contact with a resource that can help identify the problem?
- How do we best serve these children and their families using our interdisciplinary skills and different agency resources?
- How do we best support families?
    - through day care
    - by identifying and dealing with problems
    - in the context of everyday contact
- How do we get sorely needed new support services for families with young children?

B. In the process of listing concerns, we identified potential strengths and weaknesses of inter and intra-agency communication:

- Committee members began to bring case related issues and explore the best treatment agency or person to whom to make a referral.

- It was widely acknowledged that workers prefer to refer to a familiar and specific person as opposed to an anonymous agency.

- People in the group used each other in the meetings and outside the meetings seeking consultation, advice, or an appropriate referral.

- The types of service each agency has was shared and although the group members are all "seasoned workers" in this community, each learned of new services.

- More surprisingly, people even learned about some things, other people, or divisions in their own agency, that were new to them.

- It was recognized that more inter and intra-agency sharing is needed about child related issues, events, and availability of resources among co-workers (specific suggestions for this are in the recommendations).

- Greater attempts are needed, on the part of service providers, to continually bring issues of child care and consultation to the attention of agency administrators and co-workers.

- Consciousness raising occurred around the fact that different geographic offices of the same agency are separate units and need individualized approaches.

- Identified the need for more sharing of roles, job descriptions, activities, etc., among different departments of the same "core" agency, (i.e., Protective Services sharing with Day Care Licensing).

- A regular orientation system is needed for acclimating new agency staff to the child care related fields, resources, people, in an attempt to deal with lag time resulting from turnover and transfers within the agency.

- All members identified the need for more intra-agency support systems for idea and information sharing.

- There is a need for consultants to be designated from within the agencies (sanctioned from top), to consistently and specifically deal with issues of the child care community and preschool child. Preventive systems must be stressed. This type of consultation cannot be left to chance.

- Both inter and intra-agency isolation was recognized as an uncomfortable and unproductive position. It is intertwined with territory, job responsibilities, duplication of service, etc.

II. Building Resources - During the process of meeting regularly around common issues the group developed concrete resources and took steps toward supporting our communication and information sharing intentions.

A. Identification and Assessment

- Definition of population achieved by researching and compiling data on the number of preschool age children in Washtenaw County (see Appendix C).

- Assessed agency links to various child and family services.

- Support resources and developed a grid showing agency connection (see Appendix D).

- Identified programs in other counties relevant to needs of our community and sought information as to funding, support, program, (i.e., Hawthorne Center - Early Intervention Project, Lansing Crisis Child Care and Therapeutic Day Care Program).

- Population data used as interval needs assessment and catalyst for problem solving around how to meet perceived needs of children and their families. Preventive measures seen as top priority.

B. Identified existing communication resources for inter-agency dissemination of information.

- CCCRS Bi-monthly Newsletter.

- Resource booklets such as Young Children's Yellow Pages and United Way Directory.

- CCCRS referral and technical assistance systems for child care related services coordinated to families and service agency representatives.

C. Committee began both inter and intra-agency networking activities:

- As service providers we consciously began thinking in terms of interdisciplinary resources and cross disciplinary activity, (i.e., training material developed by the City-University Day Care Project).

- We began consciously generating expectations among co-workers in each member's respective agency to be responsible for communicating and sharing both within their own agency and with the larger community what is learned from attending community meetings, conferences, training sessions, etc.

III. Organization Building - Once we had assessed our situation and attempted to begin building our resources, we were able to focus our problem solving more clearly on resources we could expand on and specific organizational needs for further interagency involvement on behalf of young children and their families.

A. We expanded existing communication resources, networks and support systems:

- Revamped the CCCRS Newsletter, providing more comprehensive coverage of available resources and coordination of information dissemination for service providers.
- Updated the CCCRS 'Children's Yellow Pages'.
- *Increased the resources and availability of the consultation network and referral system (see Appendix E, Early Childhood Consultation Job Description).
- Began monthly WISD hosted interagency information sharing gatherings for the service provider community.

B. Organizational needs identified for further interagency involvement.

- A regular information sharing session where service delivery people from different agencies can meet one another face-to-face, share ideas and concerns, etc.
- A central communication network through which agency personnel receive up-to-date facts on child care related issues.
- A consultation network which provides link-up, support, training, consistency and follow-through to agency personnel designated to deal with child care centers, their population and problems.
- Utilization of child care centers as target place for impacting on whole family in a variety of areas and consistent approach to interagency service delivery.
- Joint efforts between agencies to educate child care providers on uses of consultants.
- A system in which new agency personnel can be quickly moved into the network. This may be combined with the internal orientation, procedure and would cut down on time spent developing individual networks and resources.
- Develop plans for meeting follow-up needs of families reached by the consultants.
- Sharing of Annual Reports, agency functions, events,

goals, and systems among service providers of different agencies.

- Segmentation common within a "core" agency, complicated by overload.

- Further coordination, consolidation and dissemination of information, referral, training and consultation resources among agencies.

IV. Program Building - Recommendations

A. Long-term Recommendations: Increased coordination and communication through formal and informal systems to do a lot for this community. Beyond that:

- *• More interdisciplinary team work supporting the image of the family as a whole, and bridging the gaps in service delivery.

- *• Intense research concerning the various issues of confidentiality. Children at Risk group has done work on exploring regulations and legal constraints of different disciplines and problem solving around how productive coordination can happen and at the same time honor confidentiality.

- Implementation of new interdisciplinary programs in the area of:

  - Infant-care;

  - Crisis-care;

  - After school care;

  - Sick child care;

  - Intergenerational family support and education.

- *• Develop strategies that would meet needs generated by coordinated consultation and service.

- Long-range budget planning to generate funds for consultation based on the needs of the community. Ideally joint planning and participation on project that would generate matching funds. Cross section of population insured by cross section of participation agencies and combined efforts of service delivery.

- Child care centers recognized and used as base for interdisciplinary service delivery.

- Recognition of needs for preventive based programs in such areas as:
  - Parent education;
  - Teen-age parent support programs;
  - Family planning;
  - Early comprehensive identification programs, including follow-through;
  - Systematic training for staff.

B. Short-term Recommendations.

- Continuation of interagency committee as an interdisciplinary advisory group to CCCRS.
  - Ongoing means of communication between agencies and workers serving families with 0-5 children.
  - Working group to continue to oversee interagency coordination and develop recommendations for future relationships.
- Expansion of CCCRS resources to meet the needs of service providers of 0-5 and their families.
  - Newsletter expanded, mailing list, i.e., calendar of relevant events, summaries from county-wide meetings, reports on services in the community.
  - Expansion of training and consultation network for child care providers, i.e., joint CMH-CCCRS project, (see Early Childhood Consultation Job Description in Appendix E).
  - Continuation of WISD sponsored meetings where like workers can meet face-to-face and receive interdisciplinary in-service training and support.

The work of this committee was done with thoughtful concern for the many problems young families are faced with as well as the realities of inflation and reduced budgets. We attempted to look very hard at what we already have and how we can make optimal use of it. We as a community do have needs which require added funding support but we too have needs that can best be met by pooling the many resources already existing in the county and working together to accomplish our mutual goals. The ongoing support of you as Directors of the County agencies, to the creative and thoughtful attempts of workers to find avenues for interdisciplinary and interagency work enhances the quality of service delivered and in the long and short run the quality of life in our community.

APPENDIX A20

Consultation Referral Service
coordinated by
Child Care Coordinating
And Referral Service

APPENDIX B

ASSESSMENT AND FOLLOW-THROUGH OF INDIVIDUAL CHILDREN

APPENDIX B1

NUMBER AND PERCENTAGE OF CHILDREN SCREENED FOR EACH OF THE THREE PROJECT YEARS.

SCREEN	YEAR					
	1		2		3	
	N	%[1]	N	%	N	%
DIAL	114[2]	47	236	71	228	62
Denver	2	0.8	4	1.2	10	2.7
Bayley	....	...	...	...	11	3
Health	94[2]	39	145	44	59	16
Dental	....	...	...	...	136	37

[1] Percentages are based on estimated total enrollments of 241 for the first project year, 332 for the second year, and 369 for the third year. Because actual enrollments in the centers fluctuated during the course of each year, these enrollment figures and the percentages based on them should be treated as approximations.

[2] The first year final report presented higher figures (145 for the DIAL and 127 for the health screen). The figures indicated above are based on project follow-through files as they existed at the end of the third project year.

APPENDIX B2

NUMBER OF CHILDREN RECEIVING ONE, TWO, OR THREE SCREENINGS OVER THE COURSE OF THE PROJECT.

SCREEN	NUMBER OF SCREENS			Total Number of Children Screened
	1	2	3	
DIAL (excluding ReDials during the same Project year)	418	71	6	494
Health	211	36	5	252
Dental (offerred third year only)	136	0	0	136

APPENDIX B3

NUMBER AND TYPE OF DEVELOPMENTAL PROBLEMS FOUND USING THE DIAL, FOR EACH OF THE THREE PROJECT YEARS.

PROBLEM TYPE	YEAR																	
	1						2						3					
	Total	(A)[1]	(B)[2]	(C)[3]	Net	%[4]	Total	(A)[1]	(B)[2]	(C)[3]	Net	%	Total	(A)[1]	(B)[2]	(C)[3]	Net	%
Down by DIAL Criteria	8	0	2	0	6	5.3	22	5	1	1	15	6.4	31	0	2	8	21[5]	9.2
Down in 2 areas 2 Years in a Row	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	2	.9
Down in Fine Motor and Concepts	0	0	0	0	0	0	3	0	0	0	3	1.3	6	0	0	0	6	2.6
Down in Fine Motor and Gross Motor	0	0	0	0	0	0	4	0	0	0	4	1.7	4	0	0	0	4	1.8
Down in Gross Motor and Concepts	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0
Down in Gross Motor Only	3	0	0	0	3	2.6	18	0	6	0	12	5.1	11	0	1	0	10	4.4
Down in Fine Motor Only	3	0	0	0	3	2.6	9	0	0	0	9	3.8	17	0	5	0	12	5.2
Down in Concepts Only	4	0	1	0	3	2.6	2	0	0	0	2	.8	3	1	1	0	1	.4
Totals	18	0	3	0	15	13.2	58	5	7	1	45	19.1	75	1	9	9	56	24.6

[1] English is second language

[2] Not reflective of ability

[3] ReDIAL--not down

[4] Percentages are based on the number of children screened with the DIAL each project year: 1=114; 2=236; 3=228.

[5] This figure includes two children who were down in fewer areas after a ReDIAL.

APPENDIX B4

NUMBER AND TYPES OF PROBLEMS FOUND VIA THE EPSDT HEALTH SCREEN. FIRST PROJECT YEAR

PROBLEM TYPE	PROBLEM STATUS								Total	
	Non-referrable		Under Care		Referrable		Referred			
	N	%[1]	N	%	N	%	N	%	N	%
Hearing	0	...	..	....	0	...	7	7.4	7	7.4
Vision	0	...	1	1.1	0	...	1	1.1	2	2.2
Immunization	0	...	1	1.1	0	...	1	1.1	2	2.2
Dental	0	...	2	2.1	0	...	2	2.1	4	4.2
Developmental	0	...	..	....	0	...	1	1.1	1	1.1
Behavior	0	...	1	1.1	0	...	0	....	1	1.1
Speech	1	1.1	1	1.1	1	1.1	0	....	3	3.3
Other Medical	7	6.4	11	11.7	0	...	7	6.4	25	23.4
Number of Problems	8	...	17	....	1	...	19	....	45	....
Number of Children with One or More Problems	7	7.5	16	17.0	1	1.1	18	19.2	41	43.6

---

[1] Percentages are based on the number of children screened during the first project year--94.

APPENDIX B5

NUMBER AND TYPES OF PROBLEMS FOUND VIA THE EPSDT HEALTH SCREEN. SECOND PROJECT YEAR

PROBLEM TYPE	PROBLEM STATUS									
	Non-Referrable		Under Care		Referrable		Referred		Total	
	N	%[1]	N	%	N	%	N	%	N	%
Hearing	0	...	1	.7	0	...	7	4.8	8	5.5
Vision	0	...	1	.7	0	...	6	4.1	7	4.8
Immunization	0	...	1	.7	2	1.4	10	6.9	13	9.0
Dental	0	...	4	2.8	0	...	7	4.8	11	7.6
Developmental	0	...	3	2.1	0	...	0	....	3	2.1
Behavior	6	4.1	0	....	0	...	0	....	6	4.1
Speech	0	...	0	....	0	...	0	....	0	....
Other Medical	9	6.2	12	8.3	2	1.4	19	10.3	42	26.2
Number of Problems	15	...	22	....	4	...	49	....	90	....
Number of Children with One or More Problems	13	9.0	22	15.2	3	2.1	33	22.7	65	44.8

---

[1] Percentages are based on the number of children screened during the second project year--145.

APPENDIX B6

NUMBER AND TYPES OF PROBLEMS FOUND VIA THE EPSDT HEALTH SCREEN, THIRD PROJECT YEAR

PROBLEM TYPE	PROBLEM STATUS									
	Non-referrable		Under Care		Referrable		Referred		Total	
	N	%[1]	N	%	N	%	N	%	N	%
Hearing	0	...	0	....	0	0.0	5	8.5	5	8.5
Vision	0	...	0	....	0	...	0	....	0	....
Immunization	1	1.7	0	....	0	...	4	6.8	5	8.5
Dental	0	...	3	5.1	0	...	1	1.7	4	6.8
Developmental	0	...	1	1.7	0	...	0	....	1	1.7
Behavior	1	1.7	0	....	0	...	0	....	1	1.7
Speech	0	...	0	....	0	...	0	....	0	....
Other Medical	2	3.4	2	3.4	0	...	3	5.1	7	11.9
Number of Problems	4	...	6	....	0	...	13	....	23	....
Number of Children with One or More Problems	4	6.8	6	10.2	0	...	11	18.7	20	33.9

[1] Percentages are based on the number of children screened during the third project year--59.

APPENDIX B7

NUMBERS AND TYPES OF REFERRED PROBLEMS FROM THE THIRD YEAR ON-SITE DENTAL SCREEN

Total Screens	Preventive Referral	Slight Decay	Moderate Decay	Serious Decay	Total Referrals
136	1	15	28	9	53
	.7%	11%	20.6%	6.6%	38.9%

APPENDIX B8

NUMBER OF PROBLEMS (OR REQUESTS) FOUND THROUGH GENERAL OBSERVATION OF CHILDREN IN THE PROJECT CENTERS

YEAR	SOURCE OF OBSERVATION			Total
	Project Staff	Caregiver	Parent	
1	0	2	1	3
2	0	20	7	27
3	7	20	1	28
Totals	7	42	9	58

APPENDIX B9

OBSERVED PROBLEMS/REQUESTS BY PROBLEM TYPE

PROBLEM TYPE	YEAR						Total	
	1		2		3			
	N	%	N	%	N	%	N	%
Hearing	1	33	0	..	1	3.5	2	3.2
Vision	0	..	0	..	1	3.5	1	1.6
Health	0	..	7	23	7	24.5	14	22.4
Developmental	0	..	4	13	2	7.0	6	9.6
Behavior	1	33	16	53	14	49.0	31	49.6
Speech	1	33	3	10	4	14.0	8	12.8
Total	3	..	30	..	29	....	62	....
Total Number of Children	3	..	27	..	28	....	58	....

APPENDIX B10

NUMBERS, TYPES, AND PERCENTAGES OF REFERRALS COUNTY-WIDE FOR AGES 0-21 YEARS ON THE EPSDT HEALTH SCREEN, 1976-1978[1]

PROBLEM TYPE	1976		1977		1978	
	N	%	N	%	N	%
Hearing	109	5.2	71	3.7	48	3.0
Vision	163	7.7	195	10.3	109	6.8
Immunization	215	10.2	58	3.1	45	2.8
Dental	310	14.7	446	23.5	205	12.7
Developmental	8	0.4	11	0.6	5	0.3
Mental Health/ Behavior	12	0.6	18	0.9	6	0.4
Public Health Nurse/Family Planning	76	3.6	53	2.8	39	2.4
Other Medical	335	15.5	389	20.4	286	17.7
Total Referrals	1228	....	1241	....	743	....
Total Number of Children Referred	915	43.0	889	47.0	590	37.0
Total Number of Children Screened	2111	....	1897	....	1611	....
% of Those Screened Who Are in the 0-6 Age Group	41%		50%		45%	

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[1] Source: Washtenaw County Health Department Annual Reports, 1976-1978.

APPENDIX B11

DISTRIBUTION OF FOLLOW-THROUGH PROBLEMS BY LEVEL

PROBLEM LEVEL	N	%
"Nonproblems"[1]	123	22.5
Resolved to Nonproblems	63	11.5
Already Under Care	70	12.8
Nonreferrable	145	26.4
Referrable/ Referred	147	26.9
Total	548	100.0

[1] Not a current or acute problem for the child at time of screen, but requiring some Project follow-through effort, eg., providing a list of medical resources to parents or alerting center staff to relevant information from health history.

APPENDIX B12

DISTRIBUTION OF "NONPROBLEMS" BY TYPE AND ACTION

ACTION	PROBLEM TYPE																TOTAL	
	Hearing		Vision		Dental		Developmental		Behavioral		Chronic/ Recurring		History of Hearing Problems		Other Medical			
	N	%[1]	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
List of Resources	2	2.6	3	3.9	54	70.1	2	2.6	3	3.9	..	....	..	....	13	16.9	77	62.6
History: No Follow-up	.	...	.	...	..	....	.	...	.	...	5	35.7	5	35.7	4	28.6	14	11.4
History: Follow-up	.	...	.	...	..	....	.	...	1	3.1	13	40.6	10	31.3	8	25.0	32	26.0
Total	2	1.6	3	2.4	54	43.9	2	1.6	4	3.3	18	14.6	15	12.2	25	20.3	123	100

---

[1] Percentages are row percentages.

APPENDIX B13

ISTRIBUTION OF INITIAL PROBLEMS RESOLVED TO NONPROBLEMS, BY TYPE AND ACTION

ACTION	PROBLEM TYPE												Total	
	Hearing		Vision		Developmental		Behavioral		Speech		Other Medical			
	N	%[1]	N	%	N	%	N	%	N	%	N	%	N	%
No Cause for Concern	.	....	.	...	29	70.7	3	7.3	4	9.8	5	12.2	41	65.1
Retest Negative	3	18.8	1	6.3	2	12.5	.	...	.	....	10	62.5	16	25.4
Subsumed Under Other Problem	.	....	.	...	4	66.7	.	...	1	16.7	1	16.7	6	9.5
Total	3	4.7	1	1.6	35	55.6	3	4.8	5	7.9	16	25.4	63	....

[1] Percentages are row percentages.

APPENDIX B14

DISTRIBUTION OF PROBLEMS UNDER CARE BY TYPE AND ACTION

ACTION	PROBLEM TYPE																				Total	
	Hearing		Vision		Immunization		Dental		Developmental		Behavioral		Speech		Chronic/ Recurring		History of Hearing Problems		Other Medical			
	N	%[1]	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Under Care: No Follow-up	.	...	1	2.6	1	2.6	5	12.8	6	15.4	1	2.6	.	...	4	10.3	5	12.8	16	41.0	39	55.7
Under Care: Brief Follow-up	.	...	2	14.3	1	7.1	2	14.3	2	14.3	1	7.1	1	7.1	.	....	1	7.1	4	28.6	14	20.0
Under Care: Extensive Follow-up	1	5.9	.	....	.	...	.	....	6	35.3	.	...	.	...	2	11.8	.	....	8	47.1	17	24.3
Total	1	1.4	3	4.3	2	2.9	7	10.0	14	20.0	2	2.9	1	1.4	6	8.6	6	8.6	28	40.0	70	100.0

[1] Percentages are row percentages.

APPENDIX B15

DISTRIBUTION OF NONREFERRABLE PROBLEMS BY TYPE AND ACTION

ACTION	PROBLEM TYPE										Total	
	Immunization		Developmental		Behavioral		Speech		Other Medical			
	N	%[1]	N	%	N	%	N	%	N	%	N	%
Activities/ Care Suggested	1	1.2	50	58.8	15	17.6	.	...	19	22.4	85	58.6
Observe and/or Retest Later	.	...	34	89.5	2	5.3	2	5.3	..	....	38	26.2
Extensive Consultation	.	...	6	27.3	15	68.2	.	...	1	4.5	22	15.2
Total	1	0.7	90	62.1	32	22.1	2	1.4	20	13.8	145	100.0

[1] Percentages are row percentages.

APPENDIX B16

DISTRIBUTION OF REFERRABLE AND REFERRED PROBLEMS BY TYPE AND ACTION

ACTION	PROBLEM TYPE														Total	
	Hearing		Vision		Immunization		Dental		Developmental		Speech		Other Medical			
	N	%[1]	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Referrable	..	....	.	...	2	14.3	3	21.4	7	50.0	1	7.1	1	7.1	14	9.5
Referred	18	13.5	6	4.5	14	10.5	62	46.6	10	7.5	3	2.3	20	15.0	133	90.5
Total	18	12.2	6	4.1	16	10.9	65	44.2	17	11.6	4	2.7	21	14.3	147	100.0

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[1] Percentages are row percentages.

APPENDIX B17

FINAL RESOLUTION OF REFERRED PROBLEMS

	Progress not Indicated		In Progress: Follow-Through Stopped		Follow-Through Continuing at Time of Data Collection		Problem Under Care, Improving, or Gone		Total	
	N	%	N	%	N	%	N	%	N	%
Total	46	34.5	10	7.5	6	4.5	71	53.5	133	....
Lost to Follow-through	24	18.0	4	3.0	.	...	..	....	28	21
No Need for Further Follow-through	5	3.8	5	3.8	.	...	..	....	10	7.6
Resolution Not Indicated in Records --Probably No Need For Further Follow-through	17	12.8	1	0.8	.	...	..	....	18	13.6

APPENDIX B18

FINAL RESOLUTION OF NONREFERRABLE PROBLEMS

	Progress not Indicated		In Progress: Follow-through Stopped		Follow-through Continuing at Time of Data Collection		Problem Under Care, Improving, or Gone		Total	
	N	%	N	%	N	%	N	%	N	%
Total	104	71.8	1	0.3	4	2.8	36	25.5	145	....
Lost to Follow-through	15	10.4	1	0.3	.	...	..	....	16	10.7
No Need for Further Follow-through	37	25.5	.	...	.	...	..	....	37	25.5
Resolution Not Indicated in Records --Probably No Need For Further Follow-through	52	35.9	.	...	.	...	..	....	52	35.9

APPENDIX B19
DISTRIBUTION OF DIAL RESULTS BY FOLLOW THROUGH ACTION[1]

ACTION	DOWN BY DIAL CRITERIA		FINE MOTOR/ CONCEPTS		FINE MOTOR/ GROSS MOTOR		GROSS MOTOR/ CONCEPTS		GROSS MOTOR		FINE MOTOR		CONCEPTS		Total	
	N	%[2]	N	%	N	%	N	%	N	%	N	%	N	%	N	%
NO CAUSE FOR CONCERN OR SUBSUMED UNDER OTHER PROBLEMS	14	25.4	1	33.3			1	3.4	9	31.0	5	18.5	3	10.3	33	24.1
UNDER CARE NO FOLLOW-UP	2	50.0											2	50.0	4	2.9
UNDER CARE BRIEF FOLLOW-UP	2	100.0													2	1.5
UNDER CARE EXTENSIVE FOLLOW-UP	5	100.0													5	3.6
ACTIVITIES/CARE SUGGESTED	6	13.0	1	2.2	2	4.3			17	37.0	16	34.8	4	8.7	46	33.6
OBSERVE AND/OR RETEST LATER	12	40.0	4	13.3	3	10.0			4	13.3	6	20.0	1	3.3	30	21.9
EXTENSIVE CONSULTATION	2	50.0	2	50.0											4	2.9
REFERRABLE	5	100.0													5	3.6
REFERRED	7	87.5			1	12.5									8	5.8
TOTAL	55	40.1	8	5.8	6	4.4	1	.7	30	21.9	27	19.7	10	7.3		

[1] These figures will disagree somewhat with Appendix B3 because problems continuing more than one year are counted only once on this table. Appendix B3 uses separate counts for each year, and thus counts some children twice overall.

[2] Percentages are row percentages.

APPENDIX B20

FINAL RESOLUTION OF PROBLEMS FOUND ON THE DIAL

	Progress not Indicated		In Progress: Follow-through Stopped		Follow-through Continuing at Time of Data Collection		Problem Under Care, Improving, or Gone		Total	
	N	%	N	%	N	%	N	%	N	%
al	65	66.3	7	7.1	3	3.0	23	25.5	98	....
t to low-through	14	14.3	5	5.1	.	...	..	....	19	19.4
Need for ther low-ough	15	15.3	2	2.0	.	...	..	....	17	17.3
olution Indicated Records obably Need Further low-through	36	36.7	.	...	.	...	..	....	36	36.7

APPENDIX B21

FINAL RESOLUTION OF PROBLEMS FOR CHILDREN FOUND DOWN BY DIAL CRITERIA

	Progress not Indicated		In Progress: Follow-through Stopped		Follow-through Continuing at Time of Data Collection		Problem Under Care, Improving, or Gone		Total	
	N	%	N	%	N	%	N	%	N	%
otal	13	35.1	7	18.9	2	5.4	15	40.5	37	....
ost to ollow-through	7	18.9	5	13.5	.	...	..	....	12	32.4
o Need for urther ollow-through	3	8.1	2	5.4	.	...	..	....	5	13.5
esolution ot Indicated n Records -Probably o Need or Further ollow-through	3	8.1	.	....	.	...	..	....	3	8.1

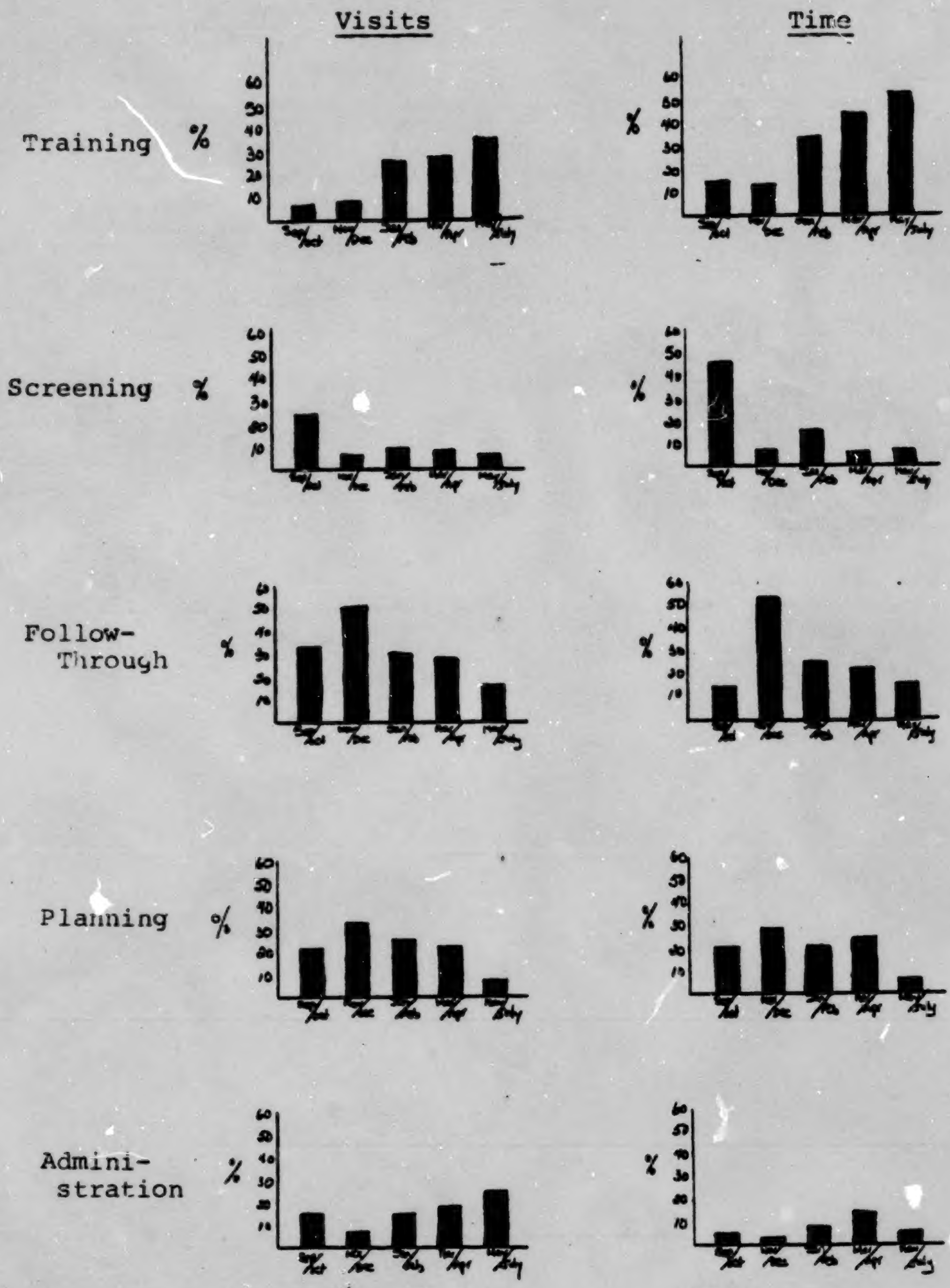
APPENDIX C1

MEAN PERCENTAGES OF CENTER CONTACTS SPENT IN VARIOUS PROJECT ACTIVITIES, BY VISITS AND BY TIME, IN THE THIRD PROJECT YEAR

Activity	Visits		Time	
	Mean	Range	Mean	Range
Training	19%	11-25	28%	14-40
Screening	11%	0-23	17%	0-30
Follow-through	33%	19-58	25%	17-47
Planning of Project Efforts	24%	10-43	22%	1-45
Administration	13%	1-28	5%	1-12
Social	1%	0-9	2%	0-13

APPENDIX C2

Bimonthly Distribution of Project Contacts With Centers, by Type of Activity



APPENDIX D1
MEAN SKILL RATINGS BY TOPIC AND SKILL AREA FROM PPE CAREGIVER QUESTIONNAIRE OF CAREGIVERS, DIRECTORS, AND PROJECT STAFF

TOPIC AREA	Caregivers		Directors		Project Staff	
	Mean	S.D.	Mean	S.D.	Mean	S.D.
Health	2.7	.7	3.2	.5	2.5	.7
Safety	2.8	.7	3.1	.4	2.1	.4
Nutrition	3.0	.6	3.4	.4	2.5	.4
Gross Motor	2.7	.6	3.0	.7	2.6	.6
Fine Motor	2.6	.8	2.7	.6	2.7	.6
Concepts	2.9	.6	3.0	.5	2.7	.6
Communication	2.8	.6	3.0	.5	2.8	.7
Social/ Emotional	3.0	.6	3.3	.6	2.7	.8
Parent Involvement	2.6	.8	3.1	.5	2.7	.8
Staff Relations	2.9	.7	3.1	.6	2.8	.9
SKILL AREA						
Knowledge	3.0	.6	3.2	.5	2.7	.6
Observation	3.0	.6	3.1	.4	2.6	.6
Program Planning	2.8	.6	3.2	.4	2.6	.8
Interaction	3.0	.5	3.4	.4	2.7	.6
Community Resources	2.4	.8	2.8	.5	2.5	.5
Record Keeping	2.5	.7	2.8	.8	2.8	.8
N	51		8		8	

APPENDIX D2

MEAN IMPORTANCE RATINGS BY TOPIC AND SKILL AREA FROM PPE CAREGIVER QUESTIONNAIRE OF CAREGIVERS, DIRECTORS, AND PROJECT STAFF

TOPIC AREA	Caregivers		Directors		Project Staff	
	Mean	S.D.	Mean	S.D.	Mean	S.D.
Health	3.4	.4	3.4	.5	3.6	.5
Safety	3.4	.4	3.5	.3	3.6	.5
Nutrition	3.4	.4	3.5	.5	3.8	.2
Gross Motor	3.4	.5	3.5	.5	4.0	0.
Fine Motor	3.3	.5	3.5	.4	4.0	0.
Concepts	3.4	.5	3.6	.4	4.0	0.
Communication	3.4	.4	3.6	.4	4.0	0.
Social/ Emotional	3.6	.4	3.7	.3	3.8	.3
Parent Involvement	3.3	.5	3.3	.6	3.8	.3
Staff Relations	3.3	.5	3.6	.4	3.9	.2
SKILL AREA						
Knowledge	3.5	.3	3.7	.3	3.4	.5
Observation	3.5	.4	3.8	.3	3.7	.3
Program Planning	3.4	.4	3.6	.3	3.6	.6
Interaction	3.5	.4	3.7	.2	3.8	.3
Community Resources	3.2	.5	3.2	.6	3.6	.6
Record Keeping	3.2	.5	3.2	.6	3.9	.2
N	51		8		2-8	

APPENDIX D3
MEAN EFFECTIVENESS RATINGS BY TOPIC AND SKILL AREA FROM PRE CAREGIVER QUESTIONNAIRE OF CAREGIVERS, DIRECTORS, AND PROJECT STAFF

TOPIC AREA	Caregivers		Directors		Project Staff	
	Mean	S.D.	Mean	S.D.	Mean	S.D.
Health	3.0	.6	3.5	.6	3.2	.9
Safety	2.3	1.0	2.7	.7	2.2	.6
Nutrition	2.8	.6	3.9	.1	3.0	.9
Gross Motor	3.2	.6	3.2	.7		
Fine Motor	3.0	.7	3.2	.7		
Concepts	2.7	.7	3.3	1.0		
Communication	2.9	.7	3.4	.7		
Social/ Emotional	3.0	.7	3.4	1.0		
Parent Involvement	2.8	.7	3.4	.5		
Staff Relations	2.9	.8	3.2	.5		
SKILL AREA						
Knowledge	3.0	.6	3.4	.5	2.9	1.1
Observation	3.0	.6	3.0	.6	3.1	1.0
Program Planning	2.8	.5	3.2	.7	2.5	.7
Interaction	2.9	.6	3.1	.8	3.1	1.0
Community Resources	3.0	.6	3.5	.4	2.8	.8
Record Keeping	2.8	.8	2.7	.9	2.8	1.0
N	12-28		3-7		0-8	

APPENDIX D4
MEAN NUMBER OF REQUESTS FOR HELP BY TOPIC AND SKILL AREA FROM PRE CAREGIVER QUESTIONNAIRE OF CAREGIVERS, DIRECTORS, AND PROJECT STAFF

TOPIC AREA	Caregivers		Directors		Project Staff	
	Mean	S.D.	Mean	S.D.	Mean	S.D.
Health	3.5	2.1	2.3	1.6	4.7	1.1
Safety	3.1	2.2	3.0	1.6	1.5	2.0
Nutrition	3.1	2.2	1.5	1.7	4.0	1.8
Gross Motor	3.8	2.3	3.5	2.5	2.5	2.0
Fine Motor	4.0	2.2	4.0	2.5	2.5	2.1
Concepts	3.4	2.4	3.9	2.3	2.0	1.7
Communication	3.7	2.3	3.0	2.8	1.9	1.8
Social/ Emotional	3.7	2.5	3.4	3.0	3.2	1.8
Parent Involvement	3.8	2.3	3.4	2.8	2.8	1.8
Staff Relations	3.4	2.5	3.4	2.5	1.7	1.8
SKILL AREA						
Knowledge	5.8	3.7	5.3	3.0	3.2	2.3
Observation	6.2	3.6	5.0	2.7	5.1	2.4
Program Planning	5.9	3.5	5.3	3.5	4.2	2.8
Interaction	5.6	3.6	4.4	3.0	4.8	2.4
Community Resources	6.3	3.2	4.8	3.2	5.5	2.2
Record Keeping	5.5	3.3	5.5	2.1	4.0	2.9
N	51		8		8	

APPENDIX D5
GOAL AREAS SELECTED BY CENTERS, WITH CORRESPONDING MEAN NEED INDICES FROM THE CAREGIVER QUESTIONNAIRE

Goal Area	Centers						Total	Need Index	
	A	B	C	D	E	F		Mean	S.D.
Social/Emotional Development	X		X	X	X	X	5	11.6	5.1
Health	X		X		X	X	4	11.5	4.4
Community Resources	X	X			X	X	5	11.4	4.3
Parent Involvement	X		X	X	X	X	5	11.4	5.2
Fine Motor		X	X	X	X	X	5	11.3	5.1
Communication								11.0	5.3
Gross Motor			X	X	X	X	4	10.8	5.1
Concepts								10.2	5.3
Staff Relations			X		X		2	10.2	5.3
Record Keeping		X					1	10.1	4.9
Safety			X	X	X	X	4	9.9	5.0
Nutrition						X	1	9.5	4.4
Sex Education				X			1		
Activities for the Autistic-like Child		X					1		
Using Foster Parents	X						1		
Staffing Protocols		X					1		
Parent Make it and Take It Workshop		X					1		
Procedures for Home Visits		X					1		
Kindergarten Readiness	X						1		
Developmental Assessment		X					1		

APPENDIX C6

PROJECT SERVICE DELIVERY APPROACHES TO CENTER GOAL AREAS

OAL AREA	WORKSHOPS	RESOURCE MATERIALS	CONSULTATION
ocial/ motional evelopment	Children's Feelings (Central) Cultural Awareness (Central) Children's Sexuality (Central) Curricular Activities Children's Behaviors Teacher Language (Centers A,C,D,F)	Workshop handouts Books on loan (Centers A&D) Booklist ("Different Books About Different Folks")	All
ealth	Childhood Illnesses	Workshop Handouts Health and Developmental Intake Forms	Centers A,C,& E
ommunity esources	Family Resource Panel (Central) Language Resource Panel (Central)	CCCRS Yellow Pages Dental Resources Resources gathered by project (Center [illegible])	All
arent nvolvement	Family Resource Panel (Central) Communicating With Parents (Centers C, F)	Parent Activity Books Books on loan (Centers A,F) CCCRS videotape (Centers A,F) Health and Developmental Intake Forms	All
ne Motor	Perceptual Motor (Central) Woodworking (Central)	Workshop handouts Books on loan (Center E) Parent Activity Books	Centers B,C,D,E
oss Motor	Gross Motor (Central) Creative Movement (Central)	Workshop handouts (Centers C,D,F) Parent Activity Books Books on loan (Center E)	Centers C,D

APPENDIX D6 (CONTINUED)

PROJECT SERVICE DELIVERY APPROACHES TO CENTER GOAL AREAS

GOAL AREA	WORKSHOPS	RESOURCE MATERIALS	CONSULTATION
aff Relations	Staff Relations (Center C) Staff Relations Follow-up (Center C)	Workshop handouts (Center C) Paper on Supportive Feedback (Centers C,E)	All
cord Keeping		Resources gathered by project	
fety	First Aid (Centers C,E,F)	Workshop handouts Safety checklist	Center E
trition	Nutrition	Workshop handouts	All
x Education	Children's Sexuality (Central)	Workshop handouts	All
tivities for the tistic-Like Child	Autism	Workshop handouts	None
ing Foster Grandparents			All
affing Protocols			All
rent Make It d Take It Workshop		Sources of possible activities Handouts for use at workshop	All
ocedures for Home Visits		Resources gathered by Project	All
ndergarten Readiness	Gross Motor (Central) Perceptual Motor (Central) Woodworking (Central) Math & Science (Central) Rhythm (Central)	Workshop handouts Books on loan	All
velopmental Assessment	Developmental Assessment Gross Motor (Central)	Workshop handouts	None

APPENDIX D6 (CONTINUED)

PROJECT SERVICE DELIVERY APPROACHES TO CENTER GOAL AREAS

GOAL AREA	WORKSHOPS	RESOURCE MATERIALS	CONSULTATION
Other Central Workshops Offerred	Cooking Math & Science Socio-Dramatic Play Rhythm		
Workshops Offered to Centers Not Involved in Goal-setting	Center M: Gross Motor Baby Exercise Children's Books Food Policies Children's Sexuality Sensories Development Activity	Workshop handouts	
	Center K: Gross Motor Pre-School Physical Fitness Perceptual Motor Manipulative Materials Math & Science Cooking Children's Feelings Children's Sexuality	Workshop Handouts	

APPENDIX D7

Sample Page from Goal Area Questionnaire

GOAL AREA: FINE MOTOR

In your daily activities in your center, how much success have you had in applying the Project's ideas, suggestions or materials presented through this approach?

	Attended/ Received						
Workshops:							
Central-(2/13) Perceptual Motor	No	Yes	have not used	no success	partial success	general success	high success
-(3/7) Woodworking	No	Yes	have not used	no success	partial success	general success	high success
Information:							
-workshop handouts	No	Yes	have not used	no success	partial success	general success	high success
-books on loan	No	Yes	have not used	no success	partial success	general success	high success

Consultation/informal discussion

How much consultation and/or informal discussion have you had with the Project staff about this goal area?

none	infrequent	occasional	frequent	extensive	have not used	no success	partial success	general success	high success

For this goal area in general, what Project ideas, suggestions or materials have been most useful? ____________________

____

To what extent has this goal been met for you?

not at all	minimally	partially	mostly	completely

APPENDIX D8

DISTRIBUTIONS OF RESPONSES TO PRESENTATION ITEMS IN THE WORKSHOP EVALUATION QUESTIONNAIRE

Items	Strongly Disagree		Disagree		Agree		Strongly Agree		Total
	N	%	N	%	N	%	N	%	N
WELL ORGANIZED	11	2.3	3	0.6	230	48.9	226	48.1	470
APPROPRIATE MANNER OF PRESENTATION	11	2.3	13	2.8	223	47.3	224	47.6	471
TOPIC COVERAGE ADEQUATE RELATIVE TO NEEDS	13	2.8	24	5.1	259	55.3	172	36.8	468

APPENDIX D9

COMPARISON OF RESPONSES FOR CENTRAL AND CENTER WORKSHOPS ON ITEM 3 OF THE WORKSHOP QUESTIONNAIRE: "THE CONTENT PRESENTED COVERED THE TOPIC ADEQUATELY FOR MY NEEDS."

Location	Strongly Disagree		Disagree		Agree		Strongly Agree		Total	
	N	%	N	%	N	%	N	%	N	%
CENTRAL	2	1.4	12	8.3	92	63.4	39	26.4	145	31
CENTER	11	3.4	12	3.7	167	51.7	133	41.2	323	69
TOTAL	13	2.8	24	5.1	259	55.3	172	36.8	468	100

Chi Square=13.6, p<.01

APPENDIX D10

DISTRIBUTION BY WORKSHOP GROUPING OF RESPONSES ON ITEM 1 OF THE WORKSHOP QUESTIONNAIRE: "THE WORKSHOP WAS WELL-ORGANIZED."

Topic Grouping	Strongly Disagree		Disagree		Agree		Strongly Agree		Total	
	N	%	N	%	N	%	N	%	N	%
Health[1]	3	6.7	1	2.2	15	33.3	26	57.8	45	9.9
Developmental areas[2]	5	2.3	1	0.5	95	44.0	115	53.2	216	47.6
Interpersonal areas[3]	3	1.6	1	0.5	106	55.2	82	42.7	193	42.5
TOTAL	11	2.4	3	0.7	216	47.7	223	49.2	453	100

Chi Square=13.7, $p<.05$

[1] Includes all health, safety, and nutrition workshops.

[2] Includes all gross motor, fine motor, concepts, communications, and developmental assessment workshops.

[3] Includes all social/emotional and staff relations workshops (participants at "informal" parent involvement workshops only responded to open-ended questionnaire items).

APPENDIX D11

DISTRIBUTION BY WORKSHOP GROUPING OF RESPONSES ON ITEM 2 OF THE WORKSHOP QUESTIONNAIRE: "THE MANNER OF PRESENTATION WAS APPROPRIATE TO THE TOPIC OF THE WORKSHOP."

Topic Grouping	Strongly Disagree		Disagree		Agree		Strongly Agree		Total	
	N	%	N	%	N	%	N	%	N	%
Health[1]	3	6.7	1	2.2	14	31.1	27	60.0	45	9.9
Developmental areas[2]	4	1.9			96	44.4	116	53.7	216	47.6
Interpersonal areas[3]	4	2.1	10	5.2	102	52.8	77	39.9	193	42.5
TOTAL	11	2.4	11	2.4	212	46.7	220	48.5	454	100

Chi Square=24.6, $p<.01$

[1] Includes all health, safety, and nutrition workshops.

[2] Includes all gross motor, fine motor, concepts, communications, and developmental assessment workshops

[3] Includes all social/emotional and staff relations workshops (participants at "informal" parent involvement workshops only responded to open-ended questionnaire items).

APPENDIX D12

DISTRIBUTION BY WORKSHOP GROUPING OF RESPONSES ON ITEM 3 OF THE WORKSHOP QUESTIONNAIRE: "THE CONTENT PRESENTED COVERED THE TOPIC ADEQUATELY, FOR MY NEEDS."

Topic Grouping	Strongly Disagree		Disagree		Agree		Strongly Agree		Total	
	N	%	N	%	N	%	N	%	N	%
Health[1]	2	4.5			20	45.5	22	50.0	44	9.8
Developmental areas[2]	5	2.3	4	1.9	120	56.1	85	39.7	214	47.5
Interpersonal areas[3]	3	1.6	17	8.8	112	58.0	61	31.6	193	42.8
TOTAL	10	2.2	21	4.7	252	55.9	168	37.3	451	100

Chi Square=19.2, $p<.01$

[1] Includes all health, safety, and nutrition workshops

[2] Includes all gross motor, fine motor, concepts, communications, and developmental assessment workshops.

[3] Includes all social/emotional and staff relations workshops (participants at "informal" parent involvement workshops only responded to open-ended questionnaire items).

APPENDIX D13

DISTRIBUTION BY WORKSHOP GROUPING OF RESPONSES ON ITEM 4 OF THE WORKSHOP QUESTIONNAIRE: "HOW MUCH DID THE WORKSHOP INCREASE YOUR BASIC KNOWLEDGE OF THIS TOPIC?"

Topic Grouping	Not at all		A little		A moderate amount		A lot		Total	
	N	%	N	%	N	%	N	%	N	%
Health[1]	1	2.2			16	35.6	28	62.2	45	10.4
Developmental areas[2]	3	1.4	42	19.5	103	47.9	67	31.2	215	49.9
Interpersonal areas[3]	3	1.8	39	22.8	79	46.2	50	29.2	171	39.7
TOTAL	7	1.6	81	18.8	198	45.9	145	33.6	489	100

Chi Square=23.7, $p<.01$

[1] Includes all health, safety, and nutrition workshops.

[2] Includes all gross motor, fine motor, concepts, communications, and developmental assessment workshops.

[3] Includes all social/emotional and staff relations workshops (participants at "informal" parent involvement workshops only responded to open-ended questionnaire items).

APPENDIX D14

DISTRIBUTION BY WORKSHOP GROUPING OF RESPONSES ON ITEM 5 OF THE WORKSHOP QUESTIONNAIRE: "HOW MUCH DID THE WORKSHOP HELP YOU IN THINKING OF PRACTICAL IDEAS FOR RECOGNIZING AND UNDERSTANDING SPECIFIC BEHAVIORS AND PROBLEMS?"

Topic Grouping	Not at all		A little		A moderate amount		A lot		Total	
	N	%	N	%	N	%	N	%	N	%
Health[1]	2	4.4	3	6.7	19	42.2	21	46.7	45	10.0
Developmental areas[2]	17	8.0	51	24.1	81	38.2	63	29.7	212	47.1
Interpersonal areas[3]	3	1.6	56	29.0	74	38.3	60	31.1	193	42.9
TOTAL	22	4.9	110	24.4	174	38.7	144	32.0	450	100

Chi Square=19.7, p<.01

[1] Includes all health, safety, and nutrition workshops.

[2] Includes all gross motor, fine motor, concepts, communications, and developmental assessment workshops.

[3] Includes all social/emotional and staff relations workshops (participants at "informal" parent involvement workshops only responded to open-ended questionnaire items).

APPENDIX D15

DISTRIBUTION BY WORKSHOP GROUPING OF RESPONSES ON ITEM 6 OF THE WORKSHOP QUESTIONNAIRE: "HOW MUCH DID THE WORKSHOP HELP YOU IN THINKING OF PRACTICAL IDEAS FOR MATCHING ACTIVITIES TO THE INDIVIDUAL CHILD'S ABILITIES, NEEDS, OR INTERESTS?"

Topic Grouping	Not at all		A little		A moderate amount		A lot		Total	
	N	%	N	%	N	%	N	%	N	%
Health[1]	15	39.5	3	7.9	10	26.3	10	26.3	38	8.7
Developmental areas[2]	3	1.4	47	21.9	98	45.6	67	31.2	215	49.0
Interpersonal areas[3]	10	5.4	48	25.8	85	45.7	43	23.1	186	42.4
TOTAL	28	6.4	98	22.3	193	44.0	120	27.3	439	100

Chi Square=83.8, $p<.01$

[1] Includes all health, safety, and nutrition workshops.

[2] Includes all gross motor, fine motor, concepts, communications, and developmental assessment workshops.

[3] Includes all social/emotional and staff relations workshops (participants at "informal" parent involvement workshops only responded to open-ended questionnaire items).

APPENDIX D16

DISTRIBUTION BY WORKSHOP GROUPING OF RESPONSES ON ITEM 7 OF THE WORKSHOP QUESTIONNAIRE: "HOW MUCH DID THE WORKSHOP HELP YOU IN THINKING OF PRACTICAL IDEAS FOR ORGANIZING IDEAS AND MATERIALS FOR PROGRAM ACTIVITIES?"

Topic Grouping	Not at all		A little		A moderate amount		A lot		Total	
	N	%	N	%	N	%	N	%	N	%
Health[1]	10	25.6	12	30.8	10	25.6	7	17.9	39	8.9
Developmental areas[2]	2	0.9	39	18.1	99	46.0	75	34.9	215	49.0
Interpersonal areas[3]	19	10.3	58	31.4	70	37.8	38	20.5	185	42.1
TOTAL	31	7.1	109	24.8	179	40.8	120	27.3	439	100

Chi Square=53.7, p<.01

[1] Includes all health, safety, and nutrition workshops.

[2] Includes all gross motor, fine motor, concepts, communications, and developmental assessment workshops.

[3] Includes all social/emotional and staff relations workshops (participants at "informal" parent involvement workshops only responded to open-ended questionnaire items).

APPENDIX D17

DISTRIBUTION BY WORKSHOP GROUPING OF RESPONSES ON ITEM 8 OF THE WORKSHOP QUESTIONNAIRE: "HOW MUCH DID THE WORKSHOP HELP YOU IN THINKING OF PRACTICAL IDEAS FOR INTERACTING WITH THE CHILD DURING PROGRAM ACTIVITIES?"

Topic Grouping	Not at all		A little		A moderate amount		A lot		Total	
	N	%	N	%	N	%	N	%	N	%
Health[1]	12	31.6	9	23.7	9	23.7	8	21.1	38	8.6
Developmental areas[2]	3	1.4	41	19.0	98	45.4	74	34.3	216	49.0
Interpersonal areas[3]	8	4.3	43	23.0	81	43.3	55	29.4	187	42.4
TOTAL	23	5.2	93	21.1	188	42.6	137	31.1	441	100

Chi Square=63.6, $p<.01$

[1] Includes all health, safety, and nutrition workshops.

[2] Includes all gross motor, fine motor, concepts, communications, and developmental assessment workshops.

[3] Includes all social/emotional and staff relations workshops (participants at "informal" parent involvement workshops only responded to open-ended questionnaire items).

APPENDIX D18

DISTRIBUTION BY WORKSHOP GROUPING OF RESPONSES ON ITEM 9 OF THE WORKSHOP QUESTIONNAIRE: "HOW MUCH DID THE WORKSHOP HELP YOU IN THINKING OF PRACTICAL IDEAS FOR BUILDING RAPPORT AND COMMUNICATION WITH CHILDREN AND/OR ADULTS?"

Topic Grouping	Not at all		A little		A moderate amount		A lot		Total	
	N	%	N	%	N	%	N	%	N	%
Health[1]	11	28.9	11	28.9	8	21.1	8	21.1	38	8.7
Developmental areas[2]	19	9.0	61	29.0	83	39.5	47	22.4	210	48.2
Interpersonal areas[3]	3	1.6	40	21.3	83	44.1	62	33.0	188	43.1
TOTAL	33	7.6	112	25.7	174	39.9	117	26.8	436	100

Chi Square=43.8, $p<.01$

[1] Includes all health, safety, and nutrition workshops.

[2] Includes all gross motor, fine motor, concepts, communications, and developmental assessment workshops.

[3] Includes all social/emotional and staff relations workshops (participants at "informal" parent involvement workshops only responded to open-ended questionnaire items).

APPENDIX D19

DISTRIBUTION BY WORKSHOP GROUPING OF RESPONSES ON ITEM 10 OF THE WORKSHOP QUESTIONNAIRE: "HOW MUCH DID THE WORKSHOP HELP YOU IN THINKING OF PRACTICAL IDEAS FOR FINDING INFORMATION AND MATERIALS THAT CAN BE USED BY THE CENTER?"

Topic Grouping	Not at all		A little		A moderate amount		A lot		Total	
	N	%	N	%	N	%	N	%	N	%
Health[1]	2	4.7	6	14.0	13	30.2	22	51.2	43	9.7
Developmental areas[2]	6	2.8	52	24.4	85	39.9	70	32.9	213	48.1
Interpersonal areas[3]	28	15.0	48	25.7	73	39.0	38	20.3	187	42.2
TOTAL	36	8.1	106	23.9	171	38.6	130	29.3	443	100

Chi Square=34.8, $p<.01$

[1] Includes all health, safety, and nutrition workshops.

[2] Includes all gross motor, fine motor, concepts, communications, and developmental assessment workshops.

[3] Includes all social/emotional and staff relations workshops (participants at "informal" parent involvement workshops only responded to open-ended questionnaire items).

APPENDIX D20

DISTRIBUTION BY WORKSHOP GROUPING OF RESPONSES ON ITEM 11 OF THE WORKSHOP QUESTIONNAIRE: "HOW MUCH DID THE WORKSHOP HELP YOU IN THINKING OF PRACTICAL IDEAS FOR ASSISTING FAMILIES TO FIND SOURCES OF HELP IN THE COMMUNITY?"

Topic Grouping	Not at all		A little		A moderate amount		A lot		Total	
	N	%	N	%	N	%	N	%	N	%
Health[1]	4	9.1	9	20.5	19	43.2	12	27.3	44	10.6
Developmental areas[2]	89	44.1	51	25.2	39	19.3	23	11.4	202	48.6
Interpersonal areas[3]	72	42.4	48	28.2	36	21.2	14	8.2	170	40.9
TOTAL	165	39.7	108	26.0	94	22.6	49	11.8	416	100

Chi Square=32.7, p<.01

[1] Includes all health, safety, and nutrition workshops.

[2] Includes all gross motor, fine motor, concepts, communications, and developmental assessment workshops.

[3] Includes all social/emotional and staff relations workshops (participants at "informal" parent involvement workshops only responded to open-ended questionnaire items).

APPENDIX D21

DISTRIBUTION BY WORKSHOP GROUPING OF RESPONSES ON ITEM 12 OF THE WORKSHOP QUESTIONNAIRE: "HOW MUCH DID THE WORKSHOP HELP YOU IN THINKING OF PRACTICAL IDEAS FOR DEVELOPING AND/OR USING A RECORD-KEEPING SYSTEM TO CHART PROGRESS, OR TO PLAN FOR A CHILD?"

Topic Grouping	Not at all		A little		A moderate amount		A lot		Total	
	N	%	N	%	N	%	N	%	N	%
Health[1]	7	15.9	12	27.3	13	29.5	12	27.3	44	10.7
Developmental areas[2]	102	51.0	49	24.5	36	18.0	13	6.5	200	48.7
Interpersonal areas[3]	89	53.3	39	23.4	28	16.8	11	6.6	167	40.6
TOTAL	198	48.2	100	24.3	77	18.7	36	8.8	411	100

Chi Square=33.4, $p<.01$

[1] Includes all health, safety, and nutrition workshops.

[2] Includes all gross motor, fine motor, concepts, communications, and developmental assessment workshops.

[3] Includes all social/emotional and staff relations workshops (participants at "informal" parent involvement workshops only responded to open-ended questionnaire items).

APPENDIX D22

OBSERVATION-RELATED RESPONSES TO THE OPEN-ENDED "CHANGE" ITEM (ITEM 16) OF THE WORKSHOP QUESTIONNAIRE COMPARED TO ITEM 5--IDEAS FOR RECOGNIZING AND UNDERSTANDING BEHAVIOR

Observation-related Response to Item 16	RESPONSE TO ITEM 5									
	Not At All		A Little		A Moderate Amount		A lot		Total	
	N	%	N	%	N	%	N	%	N	%
No	27	6.3	113	26.2	161	37.3	131	30.3	432	92.5
Yes	0	0	6	17.1	15	42.9	14	40.0	35	7.5
Total	27	5.8	119	25.5	176	37.7	145	31.0	489	100

APPENDIX D23

PROGRAM PLANNING-RELATED RESPONSES TO THE OPEN-ENDED "CHANGE" ITEM (ITEM 16) OF THE WORKSHOP QUESTIONNAIRE COMPARED TO ITEM 6--IDEAS FOR MATCHING ACTIVITIES TO INDIVIDUAL CHILD'S NEEDS

Program Planning-related Response to Item 16	RESPONSE TO ITEM 6									
	Not At All		A Little		A Moderate Amount		A lot		Total	
	N	%	N	%	N	%	N	%	N	%
No	24	7.9	74	24.5	135	44.7	69	22.8	302	66.5
Yes	10	6.6	30	19.7	61	40.1	51	33.6	152	33.5
Total	34	7.5	104	22.9	196	43.2	120	26.4	454	100

APPENDIX D24

ROGRAM PLANNING-RELATED RESPONSES TO THE OPEN-ENDED "CHANGE" ITEM (ITEM 16) OF TH RKSHOP QUESTIONNAIRE COMPARED TO ITEM 7--IDEAS FOR ORGANIZING PROGRAM ACTIVITIES

Program Planning-related Response to Item 16	RESPONSE TO ITEM 7									
	Not At All		A Little		A Moderate Amount		A lot		Total	
	N	%	N	%	N	%	N	%	N	%
No	30	9.9	86	28.5	120	39.7	66	21.9	302	66.5
Yes	8	5.3	29	19.1	60	39.5	55	36.2	152	33.5
Total	38	8.4	115	25.3	180	39.6	121	26.7	489	100

Chi Square=14.0, p<.01

APPENDIX D25

PROGRAM PLANNING-RELATED RESPONSES TO THE OPEN-ENDED "CHANGE" ITEM (ITEM 16) OF THE WORKSHOP QUESTIONNAIRE COMPARED TO ITEM 8 --IDEAS FOR INTERACTING DURING PROGRAM ACTIVITIES

Program Planning-related Response to Item 16	RESPONSE TO ITEM 8									
	Not At All		A Little		A Moderate Amount		A lot		Total	
	N	%	N	%	N	%	N	%	N	%
No	21	7.0	69	22.8	129	42.7	83	27.5	302	66.2
Yes	8	5.2	30	19.5	61	39.6	55	35.7	154	33.8
Total	29	6.4	99	21.7	190	41.7	138	30.3	489	100

APPENDIX D26

INTERACTION-RELATED RESPONSES TO THE OPEN-ENDED "CHANGE" ITEM (ITEM 16) OF THE WORKSHOP QUESTIONNAIRE COMPARED TO ITEM 9--IDEAS FOR BUILDING RAPPORT AND COMMUNICATION

Interaction-related Response to Item 16	RESPONSE TO ITEM 11									
	Not At All		A Little		A Moderate Amount		A lot		Total	
	N	%	N	%	N	%	N	%	N	%
No	35	9.0	106	27.1	145	37.1	105	26.9	391	86.3
Yes	1	1.6	12	19.4	34	54.8	15	24.2	62	13.7
Total	36	7.9	118	26.0	179	39.5	120	26.5	489	100

Chi Square=9.3, p<.05

APPENDIX D27

ITUDE-RELATED RESPONSES TO THE OPEN-ENDED "CHANGE" ITEM (ITEM 16) OF THE WORKSHOP UESTIONNAIRE COMPARED TO ITEM 9--IDEAS FOR BUILDING RAPPORT AND COMMUNICATION

itude-related Response to Item 16	RESPONSE TO ITEM 11									
	Not At All		A Little		A Moderate Amount		A lot		Total	
	N	%	N	%	N	%	N	%	N	%
No	34	8.1	110	26.1	167	39.6	111	26.3	422	93.2
Yes	2	6.5	8	25.8	12	38.7	9	29.0	31	6.8
Total	36	7.9	118	26.0	179	39.5	120	26.5	489	100

APPENDIX D28

OMMUNITY RESOURCE-RELATED RESPONSES TO THE OPEN-ENDED "CHANGE" ITEM (ITEM 16) OF T WORKSHOP QUESTIONNAIRE COMPARED TO ITEM 10--IDEAS FOR RESOURCES FOR THE CENTER

Community Resource-related Response to Item 16	RESPONSE TO ITEM 10									
	Not At All		A Little		A Moderate Amount		A lot		Total	
	N	%	N	%	N	%	N	%	N	%
No	38	8.5	108	24.1	173	38.6	129	28.8	448	97.4
Yes	1	8.3	1	8.3	5	41.7	5	41.7	12	2.6
Total	39	8.5	109	23.7	178	38.7	134	29.1	489	100

APPENDIX D29

UNITY RESOURCE-RELATED RESPONSES TO THE OPEN-ENDED "CHANGE" ITEM (ITEM 16) OF THE RKSHOP QUESTIONNAIRE COMPARED TO ITEM 11--IDEAS FOR RESOURCES FOR THE FAMILY

Community Resource-related Response to Item 16	RESPONSE TO ITEM 11									
	Not At All		A Little		A Moderate Amount		A lot		Total	
	N	%	N	%	N	%	N	%	N	%
No	166	39.4	108	25.7	94	22.3	53	12.6	421	97.2
Yes	2	16.7	2	16.7	5	41.7	3	25.0	12	2.8
Total	168	38.8	110	25.4	99	22.9	56	12.9	489	100

APPENDIX D30

RECORD KEEPING-RELATED RESPONSES TO THE OPEN-ENDED "CHANGE" ITEM (ITEM 16) OF THE WORKSHOP QUESTIONNAIRE COMPARED TO ITEM 12--IDEAS FOR DEVELOPING AND/OR USING A RECORD KEEPING SYSTEM

bservation-related Response to Item 16	RESPONSE TO ITEM 12								
	Not At All		A Little		A Moderate Amount		A lot		Tota
	N	%	N	%	N	%	N	%	N
No	207	50.0	101	24.4	73	17.6	33	8.0	414
Yes	1	8.3	2	16.7	5	41.7	4	33.3	12
Total	208	48.8	103	24.2	78	18.3	37	8.7	489

Chi Square=16.8, p<.01

APPENDIX D31

MEAN "USE" SCORES BY GOAL AREA FOR EACH PROJECT TRAINING APPROACH

GOAL AREA	TRAINING APPROACH								
	Workshops			Resource Materials			Consultation		
	N	Mean	S.D.	N	Mean	S.D.	N	Mean	S.D.
Health	11	3.6	1.0	13	3.7	1.1	4	4.0	.9
Safety	6	3.7	1.4	15	3.2	1.4			
Nutrition	3	4.0	1.0	5	3.8	.8	2	3.5	.7
Gross Motor	13	3.3	1.2	12	3.3	1.4	4	3.5	1.3
Fine Motor	17	3.6	.8	17	3.4	1.1	9	3.3	.5
Concepts	11	3.7	.8	4	3.5	1.7			
Communication	12	3.9	1.2	2	5.0	0.0			
Social/ Emotional	16	3.7	.7	15	3.7	1.0	11	3.9	.8
Parent Involvement	8	3.1	1.5	5	3.9	.9	10	3.3	.9
Staff Relations	3	3.7	.6	2	3.5	.7	2	3.5	.7
Community Resources	6	3.8	1.6	4	4.5	.6	8	3.4	.9

APPENDIX D31 (CONTINUED)

MEAN "USE" SCORES BY GOAL AREA FOR EACH PROJECT TRAINING APPROACH

GOAL AREA	TRAINING APPROACH								
	Workshops			Resource Materials			Consultation		
	N	Mean	S.D.	N	Mean	S.D.	N	Mean	S.D.
Kindergarten Readiness	2	4.5	.7	2	4.5	.7	1	3.0	0.0
Using Foster Grandparents							1	5.0	0.0
Sex Education	2	4.0	0.0	2	4.0	0.0	2	4.0	0.0
Developmental Assessment	3	5.0	0.0	3	3.3	2.1			
Activities for the Autistic-Like Child	2	1.0	0.0	2	1.0	0.0			
Home Visits				3	3.3	.6	3	3.3	.6
Staffing Protocols							1	2.0	0.0
Record Keeping				3	3.3	1.5	3	2.3	2.3
Parent Make It/Take It Workshop				2	4.0	1.4	2	4.0	1.4

APPENDIX D32

CORRELATION OF TYPES OF TRAINING RECEIVED WITH USE OF TRAINING IDEAS AND EXTENT TO WHICH GOALS WERE MET

	Consultation Received	Workshops Attended	Resource Materials Received
Workshop Use	.34	.03	.09
Resource Materials Use	.35	.08	-.06
Consultation Use	.54	.34	.05
Goals Met	.51	.18	.26

CORRELATIONS AMONG TYPES OF TRAINING USED AND THE EXTENT TO WHICH GOALS WERE MET

	Workshop Use	Resource Materials Use	Consultation Use
Workshop Use			
Resource Materials Use	.63		
Consultation Use	.33	.39	
Goals Met	.46	.42	.67

APPENDIX D33

EXTENT TO WHICH CAREGIVERS AND CENTERS PERCEIVED THAT GOALS HAD BEEN MET

	Caregivers				Centers		
		Goals Met					
l Area	N	Minimally-Not At All	Partially	Mostly or Completely	Number of Centers Choosing this Goal Area	Number of Centers in which a Majority Felt the Goal Was Met at least Partially	Number of Centers in which a Majority Felt the Goal Was Met Mostly or Completely
lth	16	3 19%	7 43%	6 38%	4	3	2
ety	18	6 33%	5 28%	7 39%	4	3	1
rition	6	1 17%	3 50%	2 33%	1	1	0
ss or	15	3 20%	5 33%	7 47%	4	3	1
e or	22	4 18%	13 54%	5 23%	5	5	1
ial/ tional	18	2 11%	9 50%	7 39%	5	4	1

APPENDIX D33 (CONTINUED)

EXTENT TO WHICH CAREGIVERS AND CENTERS PERCEIVED THAT GOALS HAD BEEN MET

	Caregivers				Centers		
		Goals Met					
l Area	N	Minimally-Not At All	Partially	Mostly or Completely	Number of Centers Choosing this Goal Area	Number of Centers in which a Majority Felt the Goal Was Met at Least Partially	Number of Centers in which a Majority Felt the Goal Was Met Mostly or Completely
rent volve-nt	15	6 40%	6 40%	3 20%	5	2	0
aff lations	5	2 40%	2 40%	1 20%	2	1	0
mmunity sources	10	4 40%	3 30%	3 30%	4	2	1
nder-rten adiness	1	0	1 100%	0	1	1	0
x ucation	2			2 100%	1	1	1
velop-ntal sessment	3		1 33%	2 67%	1	1	1

APPENDIX D13 (CONTINUED)

EXTENT TO WHICH CAREGIVERS AND CENTERS PERCEIVED THAT GOALS HAD BEEN MET

Goal Area	Caregivers				Centers		
	N	Goals Met			Number of Centers Choosing this Goal Area	Number of Centers in which a Majority Felt the Goal Was Met at least Partially	Number of Centers in which a Majority Felt the Goal Was Met Mostly or Completely
		Minimally-Not At All	Partially	Mostly or Completely			
Activities for the Autistic-like Child	3	3 100%			1	0	0
Home Visits	3	1 33%		2 67%	1	1	1
Parent Make It and Take It Workshop	3	1 33%	1 33%	1 33%	1	1	0
Staffing Protocols	3	3 100%			1	0	0
Record Keeping	3	2 62%		1 33%	1	0	0

APPENDIX D34

PRE AND POST MEAN SKILL RATINGS BY CAREGIVERS RESPONDING TO ONE OR BOTH ADMINISTRATIONS OF THE CAREGIVER QUESTIONNAIRE

Topic Area	Pretest Only		Both Pre & Post Tests					Post Test Only	
			Pre		Post		t Value		
	Mean	S.D.	Mean	S.D.	Mean	S.D.		Mean	S.D.
Health	2.7	.7	2.6	.7	2.9	.5	2.8*	2.9	.5
Safety	2.7	.6	2.8	.7	3.0	.6	2.3*	3.1	.6
Nutrition	3.0	.6	3.0	.6	3.1	.5	1.1	3.2	.6
Gross Motor	2.5	.6	2.7	.7	2.8	.5	1.3	2.8	.7
Fine Motor	2.5	.8	2.7	.7	2.9	.4	.6	2.7	.5
Concepts	2.8	.6	2.9	.6	3.0	.5	1.2	2.9	.6
Communication	2.8	.7	2.8	.6	2.9	.5	1.6	3.0	.5
Social/ Emotional	2.9	.7	3.1	.6	3.1	.5	.8	3.2	.5
Parent Involvement	2.6	.8	2.6	.9	2.8	.6	1.5	2.9	.5
Staff Relations	2.8	.7	2.9	.7	3.0	.5	.6	3.3	.4
Skill Area									
Knowledge	3.0	.6	3.1	.5	3.3	.3	2.1	3.1	.4
Observation	2.9	.6	3.0	.6	3.1	.4	2.0	3.0	.3
Program Planning	2.7	.6	2.8	.6	2.9	.5	1.0	3.1	.4
Interactive	3.0	.5	3.0	.6	3.1	.4	.9	3.3	.4
Community Resource	2.4	.9	2.4	.7	2.6	.6	2.5*	2.8	.7
Record Keeping	2.5	.7	2.5	.7	2.5	.6	.7	2.7	.6
N	26		23					10	

*p<.05

APPENDIX D35

PRE AND POST MEAN IMPORTANCE RATINGS BY CAREGIVERS RESPONDING TO ONE OR BOTH ADMINISTRATIONS OF THE CAREGIVER QUESTIONNAIRE

Topic Area	Pretest Only		Both Pre & Post Tests					Post Test Only	
			Pre		Post		t Value		
	Mean	S.D.	Mean	S.D.	Mean	S.D.		Mean	S.D.
Health	3.4	.5	3.4	.5	3.4	.5	.1	3.8	.3
Safety	3.4	.4	3.4	.5	3.4	.4	.9	3.8	.2
Nutrition	3.4	.5	3.4	.4	3.3	.5	-.2	3.8	.3
Gross Motor	3.4	.5	3.3	.5	3.3	.4	-.4	3.6	.4
Fine Motor	3.3	.5	3.3	.5	3.2	.4	-.5	3.5	.4
Concepts	3.4	.5	3.3	.6	3.3	.5	-.3	3.4	.4
Communication	3.4	.4	3.4	.5	3.4	.5	-.4	3.6	.3
Social/ Emotional	3.5	.5	3.6	.4	3.5	.4	-.8	3.7	.3
Parent Involvement	3.3	.5	3.3	.5	3.2	.4	-.5	3.5	.4
Staff Relations	3.3	.5	3.2	.7	3.2	.5	.7	3.6	.2
Skill Area									
Knowledge	3.5	.4	3.5	.4	3.5	.3	.4	3.6	.3
Observation	3.5	.4	3.5	.4	3.5	.3	-.2	3.7	.3
Program Planning	3.4	.4	3.4	.4	3.3	.3	-.6	3.6	.3
Interaction	3.5	.4	3.5	.4	3.5	.3	.3	3.8	.2
Community Resouce	3.2	.5	3.1	.5	3.0	.5	-.6	3.5	.3
Record Keeping	3.2	.5	3.1	.7	3.0	.7	-.9	3.4	.4
N	26		23					10	

APPENDIX D36

PRE AND POST MEAN EFFECTIVENESS RATINGS BY CAREGIVERS RESPONDING TO ONE OR BOTH ADMINISTRATIONS OF THE CAREGIVER QUESTIONNAIRE

Topic Area	Pretest Only		Both Pre & Post Tests					Post Test Only	
			Pre		Post		t Value		
	Mean	S.D.	Mean	S.D.	Mean	S.D.		Mean	S.D.
Health	3.1	.6	2.9	.5	2.7	.6	-.8	3.4	.5
Safety	1.9	1.1	2.5	1.1	2.4	.6	-.1	3.4	.5
Nutrition	2.5	.4	3.0	.7	2.6	.7	-.3	3.0	1.0
Gross Motor	3.0	.6	3.2	.7	3.1	.6	-.7	3.4	.5
Fine Motor	2.9	.7	3.1	.7	3.1	.5	-.4	3.2	.7
Concepts	2.6	.7	2.8	.8	2.7	.5	-.4	3.4	.7
Communication	2.7	.6	3.1	.8	2.7	.7	-1.6	3.3	.5
Social/ Emotional	2.9	.7	3.6	.4	2.8	.4	-2.9*	3.4	.7
Parent Involvement	2.6	.4	3.2	.7	2.7	.3	-1.5	3.3	.6
Staff Relations	2.7	.7	3.1	1.0	2.6	.6	-1.3	3.4	.5
Skill Area									
Knowledge	3.1	.6	3.1	.6	2.8	.4	-1.6	3.3	.3
Observation	2.9	.5	3.1	.7	2.8	.4	-1.5	3.4	.5
Program Planning	2.6	.5	3.0	.6	2.7	.5	-2.1	3.4	.5
Interaction	2.7	.5	3.0	.7	2.7	.5	-1.6	3.3	.6
Community Resource	2.9	.7	3.1	.7	2.9	.5	-1.2	3.2	.6
Record Keeping	2.5	.6	2.9	.9	2.7	.5	-1.3	3.1	.6
N	26		23					10	

*p<.05

APPENDIX D37

CORRELATIONS AMONG CAREGIVER QUESTIONNAIRE VARIABLES AND GOAL AREA QUESTIONNAIRE VARIABLES

CAREGIVER UESTIONNAIRE VARIABLE	GOAL AREA QUESTIONNAIRE VARIABLE						
	Workshop Attendance	Resource Materials Received	Consultation Received	Workshop Use	Resource Material Use	Consultation Use	Goal Met
ill ting	.00	.03	-.06	.11	-.01	.03	.17
ill ange	-.07	.05	.10	.14	-.03	.01	.20
ed dex	.20	.04	.37	.04	.00	.19	-.04
portance ting	.06	.17	.16	.27	.23	.30	.18
fectiveness ting	.19	.13	.33	.25	.33	.40	.39

APPENDIX D38

PRE AND POST MEAN SKILL RATINGS BY DIRECTORS AND PROJECT TEAMS ON THE CAREGIVER QUESTIONNAIRE

TOPIC AREA	DIRECTORS				PROJECT TEAMS			
	PRE		POST		PRE		POST	
	MEAN	S.D.	MEAN	S.D.	MEAN	S.D.	MEAN	S.D.
Health	3.2	.5	3.0	.5	2.5	.7	2.7	.6
Safety	3.1	.4	3.0	.5	2.1	.4	2.5	.5
Nutrition	3.4	.4	3.2	.6	2.5	.4	2.8	.6
Gross Motor	3.0	.7	3.0	.4	2.6	.6	2.8	.7
Fine Motor	2.7	.6	3.0	.5	2.7	.6	2.6	.8
Concepts	3.0	.5	3.0	.6	2.7	.6	2.6	.8
Communication	3.1	.5	3.0	.6	2.8	.7	2.5	.7
Social/ Emotional	3.3	.6	3.2	.6	2.7	.8	2.4	.5
Parent Involvement	3.1	.5	3.2	.6	2.7	.8	2.5	.6
Staff Relations	3.1	.6	3.3	.5	2.8	.9	2.5	.7
SKILL AREA								
Knowledge	3.2	.5	3.3	.4	2.7	.6	2.7	.6
Observation	3.1	.4	3.3	.5	2.6	.6	2.6	.6
Program Planning	3.2	.4	3.1	.5	2.6	.8	2.5	.6
Interaction	3.4	.4	3.4	.5	2.7	.6	2.7	.6
Community Resources	2.8	.5	2.7	.5	2.5	.5	2.7	.6
Record keeping	2.8	.8	2.8	.6	2.8	.8	2.4	.8
N	8		8		8		8	

APPENDIX D39

PRE AND POST MEAN IMPORTANCE RATINGS BY DIRECTORS ON THE CAREGIVER QUESTIONNAIRE

TOPIC AREA	PRE		POST	
	MEAN	S.D.	MEAN	S.D.
Health	3.4	.5	3.3	.5
Safety	3.5	.3	3.3	.4
Nutrition	3.5	.5	3.2	.7
Gross Motor	3.5	.5	3.2	.6
Fine Motor	3.5	.4	3.2	.7
Concepts	3.6	.4	3.5	.5
Communication	3.6	.4	3.3	.5
Social/ Emotional	3.7	.3	3.6	.4
Parent Involvement	3.3	.6	3.3	.6
Staff Relations	3.6	.4	3.5	.5
SKILL AREA				
Knowledge	3.7	.3	3.6	.5
Observation	3.8	.3	3.5	.5
Program Planning	3.6	.3	3.5	.5
Interaction	3.7	.2	3.6	.5
Community Resources	3.2	.6	2.9	.7
Record keeping	3.2	.6	3.1	.8
N	8		8	

APPENDIX D40

PRE AND POST MEAN EFFECTIVENESS RATINGS BY DIRECTORS AND PROJECT TEAMS ON THE CAREGIVER QUESTIONNAIRE

TOPIC AREA	DIRECTORS				PROJECT TEAMS			
	PRE		POST		PRE		POST	
	MEAN	S.D.	MEAN	S.D.	MEAN	S.D.	MEAN	S.D.
Health	3.5	.6	3.3	.5	3.2	.9	3.1	.7
Safety	2.7	.7	2.8	.8	2.2	.6	2.9	.9
Nutrition	3.9	.1	3.0	.7	3.0	.9	3.1	.6
Gross Motor	3.2	.7	3.2	.6			3.2	.6
Fine Motor	3.2	.7	3.0	.6			3.1	.7
Concepts	3.3	1.0	2.9	.4			2.8	.9
Communication	3.4	.7	2.9	.7			2.6	.6
Social/ Emotional	3.4	1.0	3.4	.6			2.8	.7
Parent Involvement	3.4	.5	2.7	.7			3.1	.5
Staff Relations	3.2	.5	2.7	.7			2.9	.7
SKILL AREA								
Knowledge	3.4	.5	3.1	.4	2.9	1.1	3.1	.5
Observation	3.0	.6	3.1	.4	3.1	1.0	3.0	.6
Program Planning	3.2	.7	3.0	.4	2.5	.7	3.1	.5
Interaction	3.1	.8	3.0	.6	3.1	1.0	2.8	.7
Community Resources	3.5	.4	3.3	.5	2.8	.8	2.9	.7
Record keeping	2.7	.9	2.7	.7	2.8	1.0	2.8	.7
N	3-7		7-8		0-8		7-8	

APPENDIX D41

TRAINING GOALS AND ATTAINMENT: FAMILY DAY CARE HOMES; THIRD PROJECT YEAR

Training goals	Home ID							Total # of Homes With Goal	Goal Attainment Change Score[4]
	11	13	14	15	16	17	18		
Developmental									
Fine Motor	*		*				*	3	6
Concepts									
Cognitive Devel.		*						1	2
Music					*			1	2
Cooking						*		1	2
Social/Emotional .				*				1	1
Cultural Awareness						*		1	3
Community Resources .									
Use of Community Resources		*						1	0
Links to Centers .			*	*			*	3	3
Contacts with Other Homes					*			1	0
Field trips			*					1	2
Nutrition	*	*						2	4
Total Number Goals/Home[1]	2	3	3	2	2	2	2	16	
Goal Attainment Change score (total)[2]	3	4	8	1	2	5	1		
Summary Goal Attainment Score[3] . .	45	43.3	56.7	35	40	55	35		

[1] Maximum = 3.
[2] Possible range 0-3/goal.
[3] Possible range 30-60.
[4] Possible range 0-3/Home

APPENDIX D42

SUMMARY GOAL ATTAINMENT SCORES[1]
FAMILY DAY CARE HOMES

	Range of Summary Goal Attainment Scores					
	30-35	36-40	41-45	46-50	51-55	56-60
Number of Caregivers	2	1	2		1	1

---

[1] Possible range 30-60.

APPENDIX E1

Agencies Addressing Problems of Interest to the EPSDT Day Care Project
(Agency Interview Data)

KEY Provides actual service Provides funding Provides services only in he case of a child referrel or a specific problem Service is available out not used consistently	1. Washtenaw County Health Department	2. Michigan Department of Public Health	3. Washtenaw Intermediate School District	4. Ann Arbor Schools Pupil Personnel	5. City of Ann Arbor CDBG	6. Child Care Coordinating & Referral Service	7. Washtenaw County D.S.S. Day Care	8.* Ann Arbor Community Services
blem 1: Helping to improve lth care practices in day e centers and homes, either king directly with center sonnel or with individual ilies with children olled in day care centers .	S	S		R	F	S		
blem 2: Helping day care ffs to develop appropriate ricula and materials for in guiding the development children	S	S	A	R		S		S
blem 3: Helping day care ffs to locate sources social services for the ilies with children in care centers		S	A		F	S	R	R
blem 4: Providing sultation and/or training staff development in the lowing areas: 1) staff eraction, 2) teacher-child eraction, and 3) teacher-ent interaction			A	R		S		S
blem 5: Helping day care ters to systematically ess the children and those need individualized help physical, social, ellectual, and/or emotional elopment	S	A	F	F	F			R
blem 6: Working with day e centers in the follow-up any children identified as ding help	S	S	R	R		S	R	R

* Early Childhood Consultation Team and the Childrens Services are also included under this label.

APPENDIX E2

Community Resources Available for Day Care Centers

Pre-School Children and Their Families

(List presented to Directors of the Day Care Centers
in the City/University Day Care Project)

1. Advocates for Safe Alternatives in Child Birth

2. Alcoholics Anonymous

3. American Diabetes Association

    -public education
    -diabetes detection during Diabetes Month (November)

4. American Red Cross

    -education programs
    -C.P.R. training

5. Ann Arbor Cleft Palate Association

    -visiting service to parent of new-borns
    -public information

6. Ann Arbor Community Center

    -summer day camp
    -adult program (including child abuse counseling)
    -rental of facilities

7. Ann Arbor Community Health Center

    -Ann Arbor Women's Health Collective
    -Children's Health Fairs

8. Ann Arbor Public Schools

    -Continuing and Community Education Department
    -Division of Early Childhood Education
    -Pupil Personnel Office (handicapped pre-schoolers)
    -Teaching-Learning Communities

9. Ann Arbor "Y"

10. Association for Children with Social or Learning Difficulties

11. Beyer Memorial Hospital

12. Bryant Community Clinic

    -health care
    -health education

HS 13. Catholic Social Services of Washtenaw County

- counseling
- foster care
- emergency food

E 14. Chelsea Schools: Special Education

- Parent Readiness Education Project (P.R.E.P.)

HS 15. Child and Family Services (at Ann Arbor and at Ypsilanti)

- counseling
- adoptions, foster care
- outreach

M 16. Child Care Coordinating and Referral Service

- consultation and technical assistance to day care centers
- day care center Director's meetings
- information (e.g. nursery school list)
- resource and toy lending library
- Job Intake and Referral Service
- community resource referrals
- bi-monthly newsletter

H 17. Children's Dental Clinic (Mack School)

- examination and treatment

M 18. City of Ann Arbor Community Development Block Grant

- Child Care Program: scholarship fund

E 19. Civil Defense: consultation on safety

E 20. Eastern Michigan University: Special Education Department

- consultation
- Student teachers

H 21. Eastern Michigan University: Speech and Hearing Clinic

- evaluation
- therapy
- parent counseling

E 22. Family Life Forum

- pre- and post-natal classes
- parenting classes

HS 23. House by the Side of the Road

H 24. Immunization Clinic (Ypsilanti)

HS 25. International Neighbors

H 26. Lamaze Childbirth Preparation Association of Ann Arbor

-childbirth preparation
-discussion
-school-age parent program

E 27. Libraries

-Ann Arbor
-Huron Valley Library Systems
  -films
  -technical service
-Ypsilanti Area Public Library

H 28. March of Dimes

-March of Dimes Clinic at University Hospital
-Public Education Program
-financial aid to birth-defected children

H 29. Michigan Association for Better Hearing and Speech

-evaluation and therapy

HS 30. Michigan Association for Emotionally Disturbed Children

-parent support group

E 31. Michigan Consolidated Gas Company: consumer information

H 32. Michigan Heart Association

-public education
-C.P.R. training
-patient information and referral

H 33. Model Cities Health Clinic: dental services

H 34. Nurse Well Child Clinic (Ypsilanti)

H 35. Nurse Well Baby Clinic (Ypsilanti)

H 36. Nurse School Age Well Child Clinic (Ypsilanti)

H 37. Packard Community Clinic

-treatment
-well-baby and child care

HS 38. Parents Anonymous (child abuse)

HS 39. Parents Without Partners (parent support group)

HS 40. Peace Neighborhood Center

-recreational and cultural programs
-social services
-counseling

HS 41. Retired Senior Volunteer Program (R.S.V.P.)

-volunteer service positions

HS 42. Salvation Army

-family services

H 43. St. Joseph Mercy Hospital

-emergency care

M 44. State of Michigan: Vocational Rehabilitation Services

-medical and physical evaluation and aid
-job training and placement

H 45. Summit Medical Center

-primary care
-ancillary services

H 46. United Cerebral Palsy of Washtenaw County

-special equipment and devices
-counseling
-referral service

The University of Michigan (entries 47-68)

E 47. U of M Center for the Continuing Education of Women

-counseling
-conferences, workshops, discussion programs

HS 48. U of M Child Development Program

-consultation on infant mental health

HS 49. U of M Children's Psychiatric Hospital

-evaluation and treatment
-pre-school programs

H 50. U of M Genetic/Heredity Clinic, for Sickle Cell test (electro-phoresis)

E 51. U of M Institute for the Study of Mental Retardation and Related Disabilities (ISMRRD)

-diagnosis and management plan
-Early Childhood Development Project
-family counseling

H 52. U of M Medical Walk-In Clinic

H 53. U of M Mott Dental Clinic

H 54. U of M Mott Hospital

E 55. U of M Nursery School: consultation

H 56. U of M Opthalmological Clinic

H 57. U of M Orthopedic Clinic

H 58. U of M Otology (E.N.T.) Clinic

H 59. U of M Pediatric Walk-In Clinic

-acute medical care
-referral service

HS 60. U of M Pediatric Psychology: evaluation

H 61. U of M Pediatric (Seizure) Rehabilitation Clinic ("Myelo" Clinic)

E 62. U of M Project Community

-volunteers

E 63. U of M Project Outreach

-volunteers

H 64. U of M School of Dentistry

-Children's Dental Clinic

E 65. U of M School of Education

-treatment
-education
-practicum students, Learning Evaluation Clinic

66. U of M Speech Clinic: evaluation and therapy

67. U of M University Hospital Emergency Room: Poison Control

68. U of M Well Child Care

    -Child Health Clinic

69. Visiting Nurse Agency of Ypsilanti/Visiting Nurse Association of Ann Arbor

    -home nursing
    -well-child clinics

70. Washtenaw Community College

    -consultation with faculty

71. Washtenaw County Assault Crisis Center

    -crisis intervention
    -temporary residences
    -outreach emergency team
    -community consultation and education
    -information and referral

72. Washtenaw County Child Risk Council: information

73. Washtenaw County Children's Dental Clinic: dental services

Washtenaw County Community Mental Health Services (WCCMHS) (entries 74-79)

74. WCCMHS Washtenaw County Community Mental Health Center

    -consultation and education

75. WCCMHS Ann Arbor Community Services

    -Crisis Walk-In Center
    -counseling, treatment
    -Early Childhood donsultation and education

76. WCCMHS Huron Valley Child Guidance Center

    -evaluation and treatment
    -day care center
    -consultation service
    -Infant Mental Health Outreach Services

HS 77. WCCMHS Washtenaw County Out-County Program

- -crisis intervention
- -counseling
- -consultation
- -information and referral

HS 78. WCCMHS Ypsilanti Area Community Services

- -crisis intervention
- -counseling
- -consultation and education

HS 79. WCCMHS Washtenaw County Community Services Agency

- -Day Care Center (Ypsilanti)
- -Foster Grandparent Program
- -Neighborhood Action Centers
- -Summer Food Service for Children

HS 80. Washtenaw County Consumer Action Center

- -Consumer Protection Division
- -mediation and prosecution of consumer complaints

E 81. Washtenaw County Cooperative Extension Service

- -family living information

HS 82. Washtenaw County Council on Alcoholism

- -therapy and referral
- -information and education programs

Washtenaw County Department of Social Services (WCDSS)
(entries 83-85)

HS 83. WCDSS Assistance Payments

HS 84. WCDSS Basic Family Service

- -education and training
- -family planning
- -home management information and counseling

HS 85. WCDSS Child Welfare Services

- -adoption, foster care
- -day care
- -Protective Services in abuse and neglect cases

86. Washtenaw County Health Department

- home health services
- school health services
- health education
- health screening
- hearing and vision conservation
- Women, Infants and Children (WIC): food program
- emergency services

Clinic Services

- Well Child Clinics
- Immunization clinics
- T.B. Clinic at St. Joseph's Mercy Hospital
- Family Planning Clinic
- Otology Clinic

87. Washtenaw County League for Planned Parenthood

- primary services
- counseling

S 88. Washtenaw County Legal Aid Society

- legal advice and representation
- community education

89. Washtenaw District Dental Society

- referral agency

90. Washtenaw Intermediate School District

High Point Center
  - education program

WISD Special Education
  - instructional programs for pre-schoolers
  - curriculum consultants

Project Find

S 91. Women's Crisis Center

- crisis intervention
- counseling
- referral

92. Ypsilanti Public Schools

Community Education Program (pre-school program)

Rackham School of Special Education
  - special classes
  - ancillary services

HS	93.	United Way
HS	94.	CETA
E	95.	High Scope Educational Research Foundation, Inc.
M	96.	Family Day Care Council

GROUPING CODES

H = Health

HS = Human Services

E = Education

M = Multi-Service

Instructions for Administration of Community Resource Checklist to Day Care Center Directors and Family Day Care Mothers

(This part of the Evaluation is to be conducted individually with each Director/Mother on the same occasion as, but immediately prior to the administration of the Director Questionnaire)

The interviewer will hand the checklist to the Director/Mother and explain :

THIS IS A LIST OF RESOURCES IN YOUR COMMUNITY THAT OFFER SERVICES TO DAY CARE CENTERS, PRE-SCHOOL AGED CHILDREN, AND THEIR FAMILIES. I HAVE SOME QUESTIONS I WANT TO ASK YOU ABOUT EACH ORGANIZATION THAT YOU HAVE HAD CONTACT WITH.

WOULD YOU BEGIN READING FROM THE TOP OF THE FIRST PAGE, AND THEN TELL ME EACH TIME YOU COME TO AN ORGANIZATION THAT YOU HAVE HAD CONTACT WITH FOR ANY PURPOSE OVER THE PAST YEAR? TELL ME THE NAME OF THE FIRST ORGANIZATION YOU HAVE HAD CONTACT WITH, WHEN YOU COME TO IT ON THE LIST.

(After Director names first organization from the list)

(1) HOW MUCH HAVE YOU USED THE ...(name of organization)... OVER THE PAST 12 MONTHS ?

(record frequency on the separate answer sheet)

(2) WHY DID YOU USE THAT SERVICE ?

(record answer verbatim on the separate answer sheet)

(3) FOR WHOM DID YOU USE THAT SERVICE ?

(record answer verbatim on the separate answer sheet)

(The interviewer will hand the Director/Mother the copy of question 4 on Response card 1)

(4) TO WHAT EXTENT DID ...(name of organization)... MEET THE NEEDS OF ...(client)... ? WERE THE NEEDS MET "NOT AT ALL"? OR "A LITTLE"? OR "A FAIR AMOUNT"? OR "COMPLETELY"? OR "DON'T YOU KNOW"?

(If no reply, repeat "TELL ME WHICH BEST DESCRIBES YOUR CONTACT WITH ...(name of organization)...?)

(5) DID THE PROJECT PLAY A ROLE IN YOUR COMING INTO CONTACT WITH ...(name of organization)...?

(If the answer is NO , mark "N" on the answer sheet, and return the Director/Mother to the checklist.)

(If the answer is YES :

* (6) DID THE PROJECT INITIATE YOUR CONTACT WITH ... (name of organization).
OR
HAD YOU ALREADY BEEN IN CONTACT WITH ... (name of organization)...
AND THE PROJECT FACILITATED THIS PARTICULAR CONTACT ?

(record "I" or "F" on the answer sheet)

(The interviewer hands the Director/Mother the copy of question 7 on Response Card 2)

* (7) THE NEXT QUESTION IS, AFTER THE PROJECT IS OVER, TO WHAT EXTENT DO YOU THINK YOU WILL MAINTAIN CONTACT WITH ... (name of organization)...? WILL YOU CONTACT THEM "NOT AT ALL"? OR "A LITTLE"? OR "A FAIR AMOUNT"? OR "OFTEN"?

(record answer on separate answer sheet)
Retain Response Card 2 until the next time question 7 is asked)

* THANK YOU.

NOW LOOK BACK TO THE CHECKLIST TO...(name of organization just evaluated)...AND TELL ME THE NAME OF THE NEXT ORGANIZATION YOU HAVE HAD CONTACT WITH, WHEN YOU SEE IT ON THE LIST.

(After Director/Mother names the next organization from the list, ask questions 1-7. Repeat questions for each organization so identified, recording answers on the answer sheet)

(When the Director/Mother comes to the end of the list, she/he is asked :

* ARE THERE ANY OTHER ORGANIZATIONS THAT YOU HAVE HAD CONTACT WITH, FOR ANY PURPOSE, OVER THE PAST YEAR ?

(If the answer is YES, write the name and address on the answer sheet, of each organization identified, and ask questions 1-7, recording the answers on the answer sheet).

(When the list is completed, take it and the Response Card 1 from the Director/Mother)

* I HAVE THREE FINAL QUESTIONS TO ASK YOU ABOUT YOUR CONTACT WITH RESOURCES IN THE COMMUNITY.

* (8) FIRST OF ALL, HAVE THERE EVER BEEN ANY SERVICES THAT YOU NEEDED, BUT YOU COULD NOT LOCATE ?

(Record any services on the bottom of the answer sheet)

(Give the Response Card 3, with Questions 9 & 10 printed)

* (9) THE NEXT QUESTION IS, TO WHAT EXTENT HAS THE PROJECT IMPROVED THE TYPE OF CONTACT WITH THOSE RESOURCES WHICH YOU HAVE USED ? HAS THE PROJECT "NOT AT ALL" IMPROVED YOUR CONTACTS, OR IMPROVED THEM "A LITTLE" ? OR "A FAIR AMOUNT"? OR IMPROVED "A GREAT AMOUNT" THE TYPE OF CONTACTS WITH THOSE RESOURCES WHICH YOU WERE ALREADY AWARE OF ?

(Record answer on the scale on the answer sheet)

* (10) THE LAST QUESTION IS, TO WHAT EXTENT DO YOU FEEL AS A RESULT OF THE PROJECT, YOU WOULD BE ABLE TO USE RESOURCES IN THE FUTURE? WILL YOUR FUTURE USE OF RESOURCES BE "NOT AT ALL" BECAUSE OF THE PROJECT? OR "A LITTLE" ? OR "A FAIR AMOUNT" ? OR "A GREAT AMOUNT"AS A RESULT OF THE PROJECT ?

(Record answer on the scale on the answer sheet)

After the Director/Mother has completed the checklist, begin instructions for the Director Questionnaire / Family Day Caregiver Questionnaire.

RESPONSE CARD 1

o what extent did the ervice meet ...'s needs ?

not at all	a little	a fair amount	completely	don't know

RESPONSE CARD 2

fter the Project is over, o what extent do you hink you will maintain ontact with..........?

not at all	a little	a fair amount	often

RESPONSE CARD 3

o what extent has the roject improved the type f contact with those esources which you have sed?

not at all	a little	a fair amount	a great amount

o what extent do you eel, as a result of the roject, you would be ble to use resources in he future ?

not at all	a little	a fair amount	a great amount

Center I.D. ________

Date________ ________

(1) I.D. #	(2) REASONS	(3) CLIENTS	(4) MEET NEEDS					(5)	(6)		(7) MAINTAIN CONTACTS			
			Not at all	a little	A fair amount	completely	don't know	N	Y		not at all	A little	a fair amount	Often
									I	F				

(8) SERVICES NEEDED

(9) IMPROVED CONTACTS

not at all	a little	a fair amount	a great amount

(10) FUTURE USE

not at all	a little	a fair amount	a grea amoun

APPENDIX E3

SERVICES UTILIZED BY PROJECT TEAMS DURING THE THIRD YEAR, CATEGORIZED BY TYPE OF SERVICE AND RESOURCE: COMMUNITY RESOURCE CHECKLIST RESPONSES

SERVICE	Health		Education		Human Service		Multi-Service		Total	
	N	%	N	%	N	%	N	%	N	%
Referral . . .	16	8.5	10	5.4	7	3.7	2	1.0	35	18.6
Consultation .	6	3.2	2	1.0	4	2.2	0		12	6.4
Program . . .	2	1.0	20	10.7	2	1.1	0		24	12.8
Administrative	4	2.1	1	0.5	12	6.4	10	5.3	27	14.3
Training . . .	52	27.6	11	5.9	12	6.4	5	2.7	80	42.6
Screening . .	10	5.3	0		0		0		10	5.3
Total	90	47.7	44	23.5	37	19.8	17	9.0	188	100

APPENDIX K4

SERVICES UTILIZED BY PROJECT TEAMS DURING THE THIRD YEAR, CATEGORIZED BY TYPE OF SERVICE AND RESOURCES: TEAM MINUTES

	Health		Education		Human Service		Multi-Service		Total	
	N[1]	%	N	%	N	%	N	%	N	%
Training Consultation/ Workshop	9	7.9	9	7.9	5	4.4	5	4.4	28	24.6
Information for Center . . .	4	3.5	3	2.6	2	1.8	5	4.4	14	12.3
Training Total .	13	11.4	12	10.5	7	6.1	10	8.8	42	36.8
Follow-through .	21	18.4	12	10.5	14	12.3	0		47	41.2
Service Delivery to Center . . .	4	3.5	3	2.6	4	3.5	2	1.8	13	11.4
Information for Project . .	2	1.8	4	3.5	1	0.9	1	0.9	8	7.0
Other	1	0.9	2	1.8	0	....	1	0.9	4	3.5
TOTALS	41	36.0	33	28.9	26	22.8	14	12.3	114	

[1] N=number of contacts.

APPENDIX E5

COMMUNITY RESOURCES USED IN FOLLOW THROUGH PROCESS ACCORDING TO CATEGORY OF SERVICE

Health		Education		Human Services		Multi-Service		Total
N	%	N	%	N	%	N	%	N
19	66[1]	4	14	6	20	0		29
	48[2]		20		20			

[1] Percent total used.

[2] Percent total resources available in same category.

APPENDIX E6

COMMUNITY RESOURCES USED IN FOLLOW THROUGH PROCESS,ACCORDING TO YEAR OF USE AND CATEGORY OF SERVICE

	Health		Education		Human Service		Multi-Service		Total
	N	%	N	%	N	%	N	%	N[1]
Year 1	3	50[2]	1	17	2	33	0		6
		75[3]		5		6.5			
Year 2	14	67	3	14	4	19	0		21
		35		15		12.9			
Year 3	7	47	3	20	5	33	0		15
		17.5		15		16.1			

[1] Not mutually exclusive totals.

[2] Percent of resources used per year.

[3] Percent of total resources available in same category.

APPENDIX E7

FREQUENCY OF UTILIZATION OF RESOURCES IN THE FOLLOW THROUGH PROCESS, ACCORDING TO CATEGORY OF SERVICE

	Health		Education		Human Service		Multi-Service		Total
	N	%[1]	N	%	N	%	N	%	N
One Year Only .	10	25	4	20	4	12.9	0		18
Two Years' Use .	4	10	3	15	2	6.5	0		9
Three Years' Use	1	2.5	0		1	3.2	0		2

[1] Percent of total resources in same category.

APPENDIX E8

FREQUENCY OF UTILIZATION OF RESOURCES IN THE FOLLOW THROUGH PROCESS FOR THREE YEARS

	"New" Resource	Used 1 Year Previously	Used 2 Years Previously	Total
Year 1	6			6
Year 2	18	3		21
Year 3	5	8	2	15
Total	29	11	2	42

APPENDIX E9

NEEDS AND RESOURCES USED BY DIRECTORS

Service Needed	Health		Education		Human Service		Multi-Service		Totals	
	N	%[1]	N	%	N	%	N	%	N	%
Referral . . .	17	7.2	10	4.3	21	9.1	1	0.4	49	20.9
Consultation .	14	6.9	5	2.2	16	6.9	4	1.7	39	16.6
Program . . .	2	0.9	19	8.1	5	2.1	3	1.2	29	12.4
Administrative	3	1.2	6	2.6	22	0.5	29	12.4	69	25.6
Training . . .	5	2.2	8	3.5	5	2.2	17	7.3	35	14.0
Screening . .	19	8.1	0	....	1	0.4	0	....	29	8.5
Unidentified .			2	0.9					2	0.9
Total . . .		25.0		21.4		20.9		23.1	234	99.8[2]

---

[1] Percentage of total services used.

[2] Rounding error accounts for remaining 0.2%.

APPENDIX E10

RESOURCES USED FROM COMMUNITY RESOURCE LIST

	Health		Education		Human Service		Multi-Service		Totals	
	N	%[1]	N	%	N	%	N	%	N	%
Identified by Directors Only	6	15	1	6	7	23	2	40	16	
Identified by Directors and Project Teams	18	45	14	68	15	48	3	60	50	
Identified by Project Team Only	6	15	1	6	2	6	0	...	9	
Totals . . .	30	75	16	80	24	77	5	100	75	78

[1] Percentage of the total agencies of this category on Community Resource List.

APPENDIX E11

FREQUENCY OF USE OF RESOURCE SERVICES BY DIRECTORS DURING THIRD YEAR

Frequency of Use	Health		Education		Human Service		Multi-Service		Total	
	N	%	N	%	N	%	N	%	N	%
Standard . .	8	3.4	11	4.7	20	8.5	17	7.3	56	23.9
1 or 2 Times	26	11.1	13	5.6	14	6.0	4	1.7	57	24.4
3 to 11 Times	10	4.3	12	5.1	19	8.1	7	3.0	48	20.5
Heavy	6	2.5	9	3.8	5	2.1	24	10.3	44	18.8
Not Mentioned	10	4.3	5	2.1	12	5.1	2	0.9	29	12.4
Total . . .	60	25.7	50	21.3	70	29.8	54	23.2	234	100

APPENDIX E12

CONSUMERS REQUIRING SERVICES AND RESOURCES USED BY DIRECTORS

Consumers	Health		Education		Human Service		Multi-Service		Total	
	N	%[1]	N	%	N	%	N	%	N	%
Multiple[2] . . .	5	2.1	16	6.8	9	3.8	9	3.8	39	16.7
Child	38	16.2	11	4.7	13	5.6	0	....	62	26.5
Parent/Family .	10	4.3	3	1.3	30	12.8	5	2.1	48	20.5
Staff	5	2.1	4	1.7	5	2.1	10	4.3	24	10.3
Center/Director	2	0.9	15	6.4	13	5.6	30	12.8	60	25.6
Unidentified .	0	....	1	0.4	0	....	0	....	1	0.4
Totals . . .	60	25.6	50	21.4	70	29.9	54	23.1	234	100

[1] Percent of total services used.

[2] Consumers from several of the categories below.

APPENDIX E13

EXTENT TO WHICH CONSUMERS' NEEDS WERE MET BY SERVICES USED BY DIRECTORS DURING THE THIRD YEAR

Extent to Which Need Met	Consumers													
	Multiple		Child		Parent/ Family		Staff		Center/ Director		Missing		Total	
	N	%[1]	N	%	N	%	N	%	N	%	N	%	N	%
Not at all	0	.... 0[2]	3	1.5 6.8	1	0.5 2.1	1	0.5 4.2	1	0.5 2.1	0	...	6	3.0
A Little	2	1.0 5.1	0	 0	1	0.5 2.1	0	 0	1	0.5 2.1	0	...	4	2.0
Fair	5	2.5 12.8	6	3.0 13.6	16	7.9 33.3	7	3.4 29.2	13	6.4 27.7	1	0.5	48	23.6
Completely	30	14.8 76.9	32	15.8 72.7	28	13.8 58.3	15	7.4 62.5	30	14.8 63.8	0	...	13.5	66.5
Don't Know	0	 0	3	1.5 6.8	2	1.0 4.2	0	 0	1	0.5 2.1	0	...	6	3.0
Missing	2	1.0 5.1	0	 0	0	 0	1	0.5 4.2	1	0.5 2.1	0	...	4	2.0
Totals	39	19.2	44	21.7	48	23.6	24	11.8	47	23.2	1	0.5	203	100

[1] Percent of total services utilized by directors.

[2] Percent of same--category of client.

APPENDIX E14

SERVICES USED "HEAVILY" BY DIRECTORS DURING THIRD YEAR

Type of Services:

Referral		Consultation		Program		Administrative		Training		Screening		To
	%[1]	N	%	N	%	N	%	N	%	N	%	
3	22.9	6	50	7	29.2	13	48.1	9	18	1	10	4

Percent of total services used in that category.

APPENDIX E14 (CONTINUED)

SERVICES USED "HEAVILY" BY DIRECTORS DURING THIRD YEAR

Type of Resources								Total	
Health		Education		Human Services		Multi-Services			
N	%[1]	N	%	N	%	N	%	N	%
6	13.6	9	20.5	5	11.4	24	54.5	44	18.8

Consumers										Total
Multiple		Child		Parent/Family		Staff		Center/Director		
N	%[1]	N	%	N	%	N	%	N	%	N
15	38.5	5	8.1	3	6.0	9	37.5	12	20	44

Extent to Which Consumers' Needs Were Met:

Not at all		A little		A fair amount		Completely		Total	
n	%[2]	n	%	n	%	n	%	n	%
0		0		7	15.9	37	84.1	44	100

[1] Percent of total services used in that category.

[2] Percent of services used heavily.

APPENDIX E15

PROJECT'S ROLE IN CONTACTS BETWEEN CENTER AND HOMES, AND SERVICES ACCORDING TO DIRECTORS AND PROJECT

Respondents	Project's Role						No Role		Total
	Facilitated		Initiated		Total				
	N	%	N	%	N	%	N	%	N
Project	27	18.8	70	48.6	97	67.4	47	32.6	144
Directors	23	10	11	5	34	15	190	85.0	224
Services for which role agreed on[1] .	4		3		7		22		29

[1] Combination of Initiated Facilitated, N=9.

APPENDIX E16

DIRECTORS' NEEDS FOR COMMUNITY RESOURCES AND THE PROJECT'S ROLE IN MAKING CONTACTS, ACCORDING TO DIRECTORS

	Project's Role									
	Facilitated		Initiated		Total		No Role		Total	
	N	%	N	%	N	%	N	%	N	%
Referral . .	5	2.2	0	...	5	2.2	44	19.6	49	21.9
Consultation	3	1.4	3	1.4	6	2.8	31	1.4	37	16.5
Program . .	1	0.4	0	...	1	0.4	28	12.5	29	12.9
Center . . .	4	1.8	1	0.4	5	2.2	50	22.3	55	24.6
Training . .	6	2.7	1	0.4	7	3.1	27	12.1	34	15.2
Screening .	4	1.8	6	2.7	10	4.5	10	4.5	20	8.9
Total . .	23	10	11	5.0	34	15	190	85	224	

APPENDIX E17

SUMMARY OF RESOURCES USED BY AND ON BEHALF OF CENTERS AND HOMES

DATA SOURCE	CENTERS								Range	Mean
	A	B	C	D	E	F	K	M		
C.R. list:[1] Director	12	38	8	7	11	15	6	39	6-39	16
C.R. list: Project	17	31	13	19	26	28	22	3	3-31	19
Follow-through	4	6	2	3	4	5	2	0	2-6	3
Team Minutes	10	15	6	17	8	12	5	6	5-17	10
Total Different Resources[2]	25	50	19	37	37	38	24	41	19-50	34

[1] Community Resource Checklist

[2] Grand Total=78 different resources

APPENDIX E18

DIRECTORS' EVALUATION OF PROJECT'S ROLE IN RELATION TO CONTACT WITH COMMUNITY RESOURCES

	Not at all		A little		A fair amount		Often		(Missing)		Total
	N	%	N	%	N	%	N	%	N	%	N
Extent Directors maintain contact with resources	2	0.9	9	3.8	42	17.9	127	54.3	54	23.1	234

APPENDIX E18 (CONTINUED)

DIRECTORS' EVALUATION OF PROJECT'S ROLE IN RELATION TO CONTACT WITH COMMUNITY RESOURCES

NUMBER OF DIRECTORS

	Not at all	A little	A fair amount	A great amount	otal
Extent to which the project helped improve contacts	1	2	4	1	8
Future use as a Result of Project's Efforts	1	1	3	3	8

APPENDIX E19

City- University Day Care Project Symposium Questionnaire

(Community)

The purpose of this questionnaire is to evaluate this symposium and to obtain your reactions to the desirability and feasibility of the Project's approach.

It is not our purpose to compare individuals or agencies. Code numbers on the questionnaire will be used by the evaluation staff to record the returns of the questionnaires, and for grouping responses from similar sources; names will not be disclosed to Project staff or to the sponsoring agency. Summary information of questionnaire results will be included in the final evaluation report to the Project sponsor (HEW). In this report, the confidentiality of your responses as individuals and the organization you represent will be maintained.

If you have any questions please check with Nancy Shiffler or Margaret McNiven of the evaluation staff.

Please turn in this questionnaire to the evaluators or place it in one of the available boxes before you leave today.

City-University Day Care Project Symposium Questionnaire

Session attended A B C D Lunch Discussion I II III IV V VI

Please check one box for each question.

1. To what extent do the Project's activities correspond to your own current activities involving

a. health and developmental screeening for chilren and families	Services not currently offered	No correspondence	Some correspondence	Quite a bit of correspondence	Identical or nearly identical
b. follow-through services for children and families	Services not currently offered	No correspondence	Some correspondence	Quite a bit of correspondence	Identical or nearly identical
c. support services for children and families	Services not currently offered	No correspondence	Some correspondence	Quite a bit of correspondence	Identical or nearly identical
d. training services for Day Care personnel	Services not currently offered	No correspondence	Some correspondence	Quite a bit of correspondence	Identical or nearly identical
e. consultation services for Day Care Centers and/or Homes	Services not currently offered	No correspondence	Some correspondence	Quite a bit of correspondence	Identical or nearly identical
f. interaction with other agencies and groups in your community	not currently occurring	No correspondence	Some correspondence	Quite a bit of correspondence	Identical or nearly identical
g. other ____________________	Services not currently offered	No correspondence	Some correspondence	Quite a bit of correspondence	Identical or nearly identical

2. Did this symposium suggest other activities or approaches you might use involving:

a. health and developmental screening for children and families

None	A few	A moderate amount	A lot

b. follow-through services for children and families

None	A few	A moderate amount	A lot

c. support services for children and families

None	A few	A moderate amount	A lot

d. training services for Day Care personnel

None	A few	A moderate amount	A lot

e. consultation services for Day Care Centers and/or Homes

None	A few	A moderate amount	A lot

f. interaction with other agencies and groups in your community

None	A few	A moderate amount	A lot

g. other ______________________________

None	A few	A moderate amount	A lot

3. If your community were to set up an interagency program incorporating the Project's approach, what do you see as potential roles for your agency or organization?

a. actively providing direct services to Day Care Centers and/or Homes	No involvement	Minimal role	Secondary role	Primary role
b. actively providing direct services to children and families	No involvement	Minimal role	Secondary role	Primary role
c. responding to specific referrals from centers and/or other agencies	No involvement	Minimal role	Secondary role	Primary role
d. serving in a co-ordinating role	No involvement	Minimal role	Secondary role	Primary role
e. being a source of information for centers and/or families	No involvement	Minimal role	Secondary role	Primary role
f. serving as a source of funding for centers or agencies	No involvement	Minimal role	Secondary role	Primary role
g. receiving services	No involvement	Minimal role	Secondary role	Primary role
h. other ______________________	No involvement	Minimal role	Secondary role	Primary role

4. To what extent do you see the following as potential obstacles to your agency/organization taking part in such a program?

a. lack of funds	Not an obstacle	A minor obstacle	An important obstacle	A major obstacle
b. priorities for distributing funds	Not an obstacle	A minor obstacle	An important obstacle	A major obstacle
c. lack of time	Not an obstacle	A minor obstacle	An important obstacle	A major obstacle
d. priorities for allocating time	Not an obstacle	A minor obstacle	An important obstacle	A major obstacle
e. lack of available staff	Not an obstacle	A minor obstacle	An important obstacle	A major obstacle
f. priorities in assigning staff	Not an obstacle	A minor obstacle	An important obstacle	A major obstacle
g. insufficient communication within your agency or organization	Not an obstacle	A minor obstacle	An important obstacle	A major obstacle
h. insufficient communication among agencies/organizations	Not an obstacle	A minor obstacle	An important obstacle	A major obstacle
i. differences in agency/organization operations and interests	Not an obstacle	A minor obstacle	An important obstacle	A major obstacle
j. possible infringements on rights to privacy	Not an obstacle	A minor obstacle	An important obstacle	A major obstacle
k. other ____________________	Not an obstacle	A minor obstacle	An important obstacle	A major obstacle

5. For those obstacles that you rated as "important" or "major", how might they be overcome?

6. How desirable do you feel it would be for your community to set up a program based on the Project's approach?

Not desirable	Minimally desirable	Moderately desirable	Very desirable

7. Given the current activities of your organization, the obstacles you identified, and your perception of the value of the Project's approach, how feasible do you feel it would be for your community to set up a program based on the Project's approach?

Not at all feasible	Minimally feasible	Moderately feasible	Very feasible

City- University Day Care Project Symposium Questionnaire

(State)

The purpose of this questionnaire is to evaluate this symposium and to obtain your reactions to the desirability and feasibility of the Project's approach.

It is not our purpose to compare individuals or agencies. Code numbers on the questionnaire will be used by the evaluation staff to record the returns of the questionnaires, and for grouping responses from similar sources; names will not be disclosed to Project staff or to the sponsoring agency. Summary information of questionnaire results will be included in the final evaluation report to the Project sponsor (HEW). In this report, the confidentiality of your responses as individuals and the organization you represent will be maintained.

If you have any questions please check with Nancy Shiffler or Margaret McNiven of the evaluation staff.

Please turn in this questionnaire to the evaluators or place it in one of the available boxes before you leave today.

City-University Day Care Project Symposium Questionnaire

Session attended A B C D   Lunch Discussion I II III IV V VI

Please check one box for each question.

1. To what extent do the Project's activities correspond to other programs in the state which you are funding or otherwise supporting, involving:

a. health and developmental screeening for chilren and families	Services not currently offered	No correspondence	Some correspondence	Quite a bit of correspondence	Identical or nearly identical
b. follow-through services for children and families	Services not currently offered	No correspondence	Some correspondence	Quite a bit of correspondence	Identical or nearly identical
c. support services for children and families	Services not currently offered	No correspondence	Some correspondence	Quite a bit of correspondence	Identical or nearly identical
d. training services for Day Care personnel	Services not currently offered	No correspondence	Some correspondence	Quite a bit of correspondence	Identical or nearly identical
e. consultation services for Day Care Centers and/or Homes	Services not currently offered	No correspondence	Some correspondence	Quite a bit of correspondence	Identical or nearly identical
f. interaction with other agencies and groups in your community	not currently occurring	No correspondence	Some correspondence	Quite a bit of correspondence	Identical or nearly identical
g. other ____________	Services not currently offered	No correspondence	Some correspondence	Quite a bit of correspondence	Identical or nearly identical

2. Did this symposium suggest ways in which you might facilitate the operation of local programs involving:

a. health and developmental screening for children and families

None	A few	A moderate amount	A lot

b. follow-through services for children and families

None	A few	A moderate amount	A lot

c. support services for children and families

None	A few	A moderate amount	A lot

d. training services for Day Care personnel

None	A few	A moderate amount	A lot

e. consultation services for Day Care Centers and/or Homes

None	A few	A moderate amount	A lot

f. interaction with other agencies and groups in your community

None	A few	A moderate amount	A lot

g. other ______________________

None	A few	A moderate amount	A lot

3. If a community were to set up an interagency program incorporating the Project's approach, what do you see as potential roles for the local unit of your agency/organization?

a. actively providing direct services to Day Care Centers and/or Homes	No involvement	Minimal role	Secondary role	Primary role
b. actively providing direct services to children and families	No involvement	Minimal role	Secondary role	Primary role
c. responding to specific referrals from centers and/or other agencies	No involvement	Minimal role	Secondary role	Primary role
d. serving in a co-ordinating role	No involvement	Minimal role	Secondary role	Primary role
e. being a source of information for centers and/or families	No involvement	Minimal role	Secondary role	Primary role
f. serving as a source of funding for centers or agencies	No involvement	Minimal role	Secondary role	Primary role
g. receiving services	No involvement	Minimal role	Secondary role	Primary role
h. other ______________________	No involvement	Minimal role	Secondary role	Primary role

4. For most communities, to what extent would the following be obstacles to local units of your agency/organization taking part in such a program?

a. lack of funds	Not an obstacle	A minor obstacle	An important obstacle	A major obstacle
b. priorities for distributing funds	Not an obstacle	A minor obstacle	An important obstacle	A major obstacle
c. lack of time	Not an obstacle	A minor obstacle	An important obstacle	A major obstacle
d. priorities for allocating time	Not an obstacle	A minor obstacle	An important obstacle	A major obstacle
e. lack of available staff	Not an obstacle	A minor obstacle	An important obstacle	A major obstacle
f. priorities in assigning staff	Not an obstacle	A minor obstacle	An important obstacle	A major obstacle
g. insufficient communication within your agency or organization	Not an obstacle	A minor obstacle	An important obstacle	A major obstacle
h. insufficient communication among agencies/organizations	Not an obstacle	A minor obstacle	An important obstacle	A major obstacle
i. differences in agency/organization operations and interests	Not an obstacle	A minor obstacle	An important obstacle	A major obstacle
j. possible infringements on rights to privacy	Not an obstacle	A minor obstacle	An important obstacle	A major obstacle
k. other ______________________	Not an obstacle	A minor obstacle	An important obstacle	A major obstacle

5. For those obstacles that you rated as "important" or "major", how might they be overcome?

6. How desirable do you feel it would be for communitiies in the state to set up programs incorporating the Project's approach?

Not desirable	Minimally desirable	Moderately desirable	Very desirable

7. Given what you know about the operations of your local units in the state, the obstacles you identified, and your perception of the value of the Project's approach, how feasible do you feel it would be for communities in the state to set up programs based on the Project's approach

Not at all feasible	Minimally feasible	Moderately feasible	Very feasible

APPENDIX E20

WASHTENAW COUNTY COMMUNITY RESOURCE REPRESENTATIVES' RATINGS OF THE APPLICABILITY OF THE PROJECTS' MODEL ACCORDING TO SYMPOSIUM QUESTIONNAIRE RESPONSE

		Desirability					
		Low		High		Total	
		N	%	N	%	N	%
Feasibility	Low	2	18.2	1	9.1	3	27.3
	High	0		8	72.7	8	72.7
	Total	2	18.2	9	81.8	11	100